

## 1567 CERTIFICATE OF DEATH

Reg. Dist. No.

01547

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>13 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4 Bloomingdale Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Catherine L. Adams</b>		4. DATE OF DEATH <b>February 5, 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 17, 1875</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Blucher</b>		14. MOTHER'S MAIDEN NAME <b>Susie Sours</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-03-2287 D</b>	
17. INFORMANT <b>Mrs. Charles Henn, Sr.</b>		Address <b>4 Bloomingdale Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO (b) <b>Hypertension</b> DUE TO (c) <b>Degenerative Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>2/5/60</b> <b>320A. M.</b>	
21. I certify that I attended the deceased from <b>2/4/60</b> to <b>2/5/60</b> , that I last saw the deceased alive on <b>2/4/60</b> , and that death occurred at <b>320A. M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>1303 Frederick Rd. Catonsville, Md.</b> DATE SIGNED <b>2/6/60</b>	
ACTUAL SIGNATURE <b>W.E. McGrath</b>		M.D. <b>1303 Frederick Rd., Catonsville 28</b>	
PHYSICIAN'S NAME (Type) <b>W.E. McGrath M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/8/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur J. 1328 Sulphur Spring Rd.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. 1328 Sulphur Spring Rd.</b>	
24a. REC'D BY REGISTRAR <b>FEB 8 '60</b>		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		45		Male		White		10/15/1910		New York City	
Cause of Death		Occupation		Education		Marital Status		Religion		Burial Place	
Heart Disease		Teacher		High School		Married		Catholic		St. Mary's Church	
Signature of Physician		Signature of Registrar		Signature of Witness		Signature of Deceased		Signature of Family		Signature of Minister	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issuance		Authority		Remarks		Remarks		Remarks	
10/15/1910		New York City		Health Officer		[Blank]		[Blank]		[Blank]	

## CERTIFICATE OF DEATH

01548

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Md.</b> c. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1 Day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in Pines</b>		d. STREET ADDRESS <b>411 Mt. Holly St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>J.</b> Last <b>Aidt</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>20</b> Year <b>1960</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 31, 1873</b>
9. AGE (In years last birthday) <b>86</b> yrs		IF UNDER 1 YEAR: Months <b>3</b> Days <b>10</b> Hours <b>4</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Engraver Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Engraving</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Louis Aidt</b>		14. MOTHER'S MAIDEN NAME <b>Anna Nay</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>--</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Mrs. John Wetzler</b>		Address <b>414 S. Augusta Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> <b>443X</b> DUE TO <b>Kral Infection + Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardio-Vascular (Hypertensive) Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>About 9 wk.</b> <b>About 10 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/31</b> , 19 <b>18</b> , to <b>2/20</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>11/27</b> , 19 <b>59</b> , and that death occurred at <b>4:30 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>2/24/60</b>			
ACTUAL SIGNATURE <b>Theodore H. Morrison</b> M.D.		PHYSICIAN'S NAME (Type) <b>Theodore H. Morrison</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-22-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Farley Funeral Home</b>		ADDRESS <b>Catonsville Md.</b>	24a. REC'D BY REGISTRAR DATE <b>FEB 24 '60</b>
		24b. REGISTRAR'S SIGNATURE <b>C. H. Kline</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or removal within 72 hours after death.







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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01550

1570 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>22 Hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>3446 Keswick Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>W.</b> Last <b>BABYLON</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>26</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 7, 1912</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months <b>12</b> Days <b>14</b> Hours <b>14</b> Min.		IF UNDER 24 HRS. Months <b>12</b> Days <b>14</b> Hours <b>14</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Helper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking Firm</b>		11. BIRTHPLACE (State or foreign country) <b>Westminster, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Raymond H. Babylon</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Fritz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WW II</b>				16. SOCIAL SECURITY NO. <b>218-09-1829</b>			
17. INFORMANT <b>Clin. Records, VAH, Balto 18, Md. Ft. Howard. Division</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EDEMA</b> <b>593X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE HEART DISEASE</b> DUE TO (c) <b>UREMIA, CHRONIC, SECONDARY TO GLOMERULONEPHRITIS</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 MINUTES</b> <b>UNKNOWN</b> <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 25, 1960</b> , to <b>February 26, 1960</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>February 26, 1960</b> , and that death occurred at <b>12:14 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>John D. Talbert</b>				22b. DATE SIGNED <b>2-26-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>John D. Talbert</b>				22d. ADDRESS <b>M.D. VAH Baltimore Md - Ft Howard Division</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3/1/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	
23d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>				(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Austin E. Donovan</b>				ADDRESS <b>3818 Roland Ave Balto. 11, Md</b>		25a. REC'D BY REGISTRAR <b>MAR 1 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>C. E. Harris</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## REVISIONS OF

Figure 1

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## CERTIFICATE OF DEATH

Reg. Dist. No.

01551

1571

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Md.</b> c. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>919 Marksworth Rd.</b>		d. STREET ADDRESS <b>919 Marksworth Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>MARSHALL</b> Middle <b>E.</b> Last <b>BARGER</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>9</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 31, 1896</b>
9. AGE (In years lost birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>63</b> Days <b>63</b> Hours <b>63</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Locomotive Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Md.</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown Hightman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Mr. Harold W. Good - 919 Marksworth Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerotic CVD-</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatoid arthritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>p. m.</b> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 8, 1957</b> to <b>Feb 9, 1960</b> , that I last saw the deceased alive on <b>Feb 8, 1960</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Kennard Yaffe</b>		ADDRESS (Street, city or town, state) <b>5501 Forest Park Ave</b>	
PHYSICIAN'S NAME (Type) <b>KENNARD YAFFE M.D.</b>		DATE SIGNED <b>Balto 7, Ind.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/9/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Frederick Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Peete Funeral Home - Annapolis Md</b>		24a. REC'D BY REGISTRAR <b>FEB 9 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



100-10

RECEIVED BY MAIL

1921

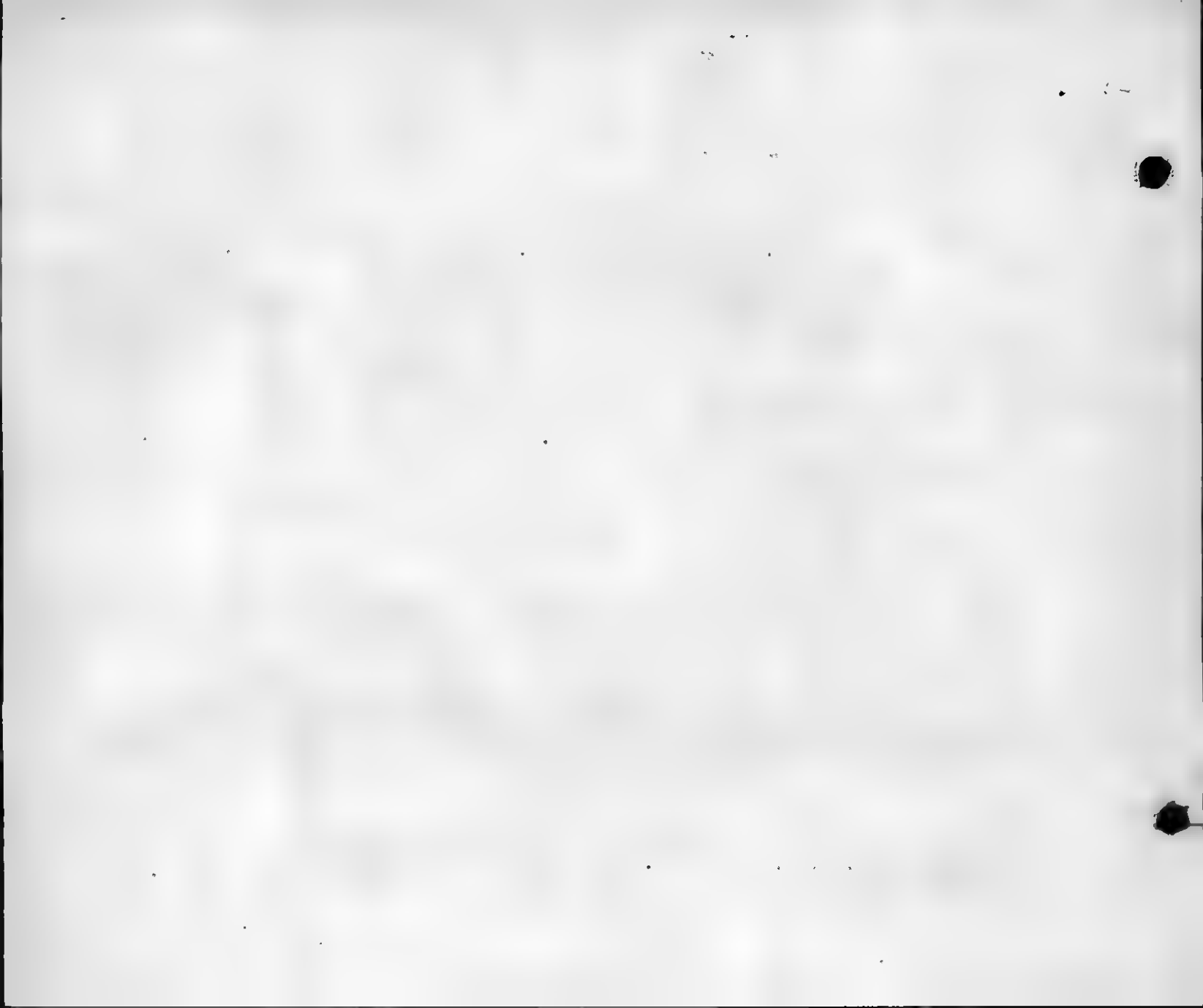
## 01552

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">1572</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington - Ne. Baltimore</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>300 Warwick Road</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington - Ne. Baltimore</u> d. STREET ADDRESS <u>300 Warwick Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Martin J. Early, (Marcelus T. Miezef)</u> First Middle Last <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Oct. 20, 1888</u> <b>9. AGE</b> (In years last birthday) <u>71</u> <b>IF UNDER 1 YEAR</b> <b>IF UNDER 24 HRS.</b> Months Days Hours Min.		<b>4. DATE OF DEATH</b> <u>Feb. 7, 1960</u> <b>19</b> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Tailor</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Lithuana</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Lithuana</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>Lithuanian</u> <b>13. FATHER'S NAME</b> <u>Lawrence Miezef</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Not Known</u> <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>312 03 5724</u> <b>17. INFORMANT</b> <u>A. Voloni</u> <u>Early</u> <u>300 Warwick Rd</u> <u>Baltimore</u> <u>Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</b> <u>Coronary thrombosis</u> <b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b> <u>DUE TO</u> <b>(c)</b> <u>DUE TO</u> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>Hour</u> <u>a. m.</u> <u>19</u> <u>p. m.</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)		<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>	
<b>ACTUAL SIGNATURE</b> <u>Geo. W. Kieffer</u> <b>M.D.</b> <b>EXAMINER'S NAME (Type)</b> <u>Geo. W. Kieffer M.D.</u> <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>2/10/60</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park Cemtery</u> <b>22d. LOCATION (City, town, or county)</b> <u>Baltimore, Maryland</u> (State)		<b>CHIEF MEDICAL EXAMINER <input type="checkbox"/></b> <b>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></b> <b>DEPUTY MEDICAL EXAMINER <input type="checkbox"/></b> <b>DATE SIGNED</b> <u>Feb. 7, 1960</u> <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Howard H. Hubbard</u> <b>ADDRESS</b> <u>4107 Wilkens Avenue</u> <b>24a. RECEIVED BY REGISTRAR</b> <u>FEB 11 1960</u> <b>DATE</b> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		c. LENGTH OF STAY IN 1b Cockeysville, Md. X		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville, Md. X		d. STREET ADDRESS Warren Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Ellen		Middle Alberta		Last Barron		4. DATE OF DEATH Month Feb.		Day 21		Year 1960							
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 12, 1876		9. AGE (In years lost birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph Freeland				14. MOTHER'S MAIDEN NAME Annie Nace				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none				17. INFORMANT Herbert F. Barron, Warren Rd. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]												INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage												2 yrs.							
331X DUE TO												Hypertension							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												(b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2-3, 1958, to 2/21, 1960, that I last saw the deceased alive on 2-20, 1960, and that death occurred at 9:30 A.M. from the causes and on the date stated above.																			
ACTUAL SIGNATURE Bennett A. Stock				M.D. 19W Seminary Ave				DATE SIGNED 2/22/60											
PHYSICIAN'S NAME (Type) Bennett A. Stock				19W Seminary Ave				Phoenix, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Feb. 24				22c. NAME OF CEMETERY OR CREMATORY Poplar Grove				22d. LOCATION (City, town, or county) (State) Phoenix, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Jm. Cook-Towson, Inc. 1050 York Rd. Md. 4								24a. REC'D BY REGISTRAR FEB 23 1960				24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL: The attending physician: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

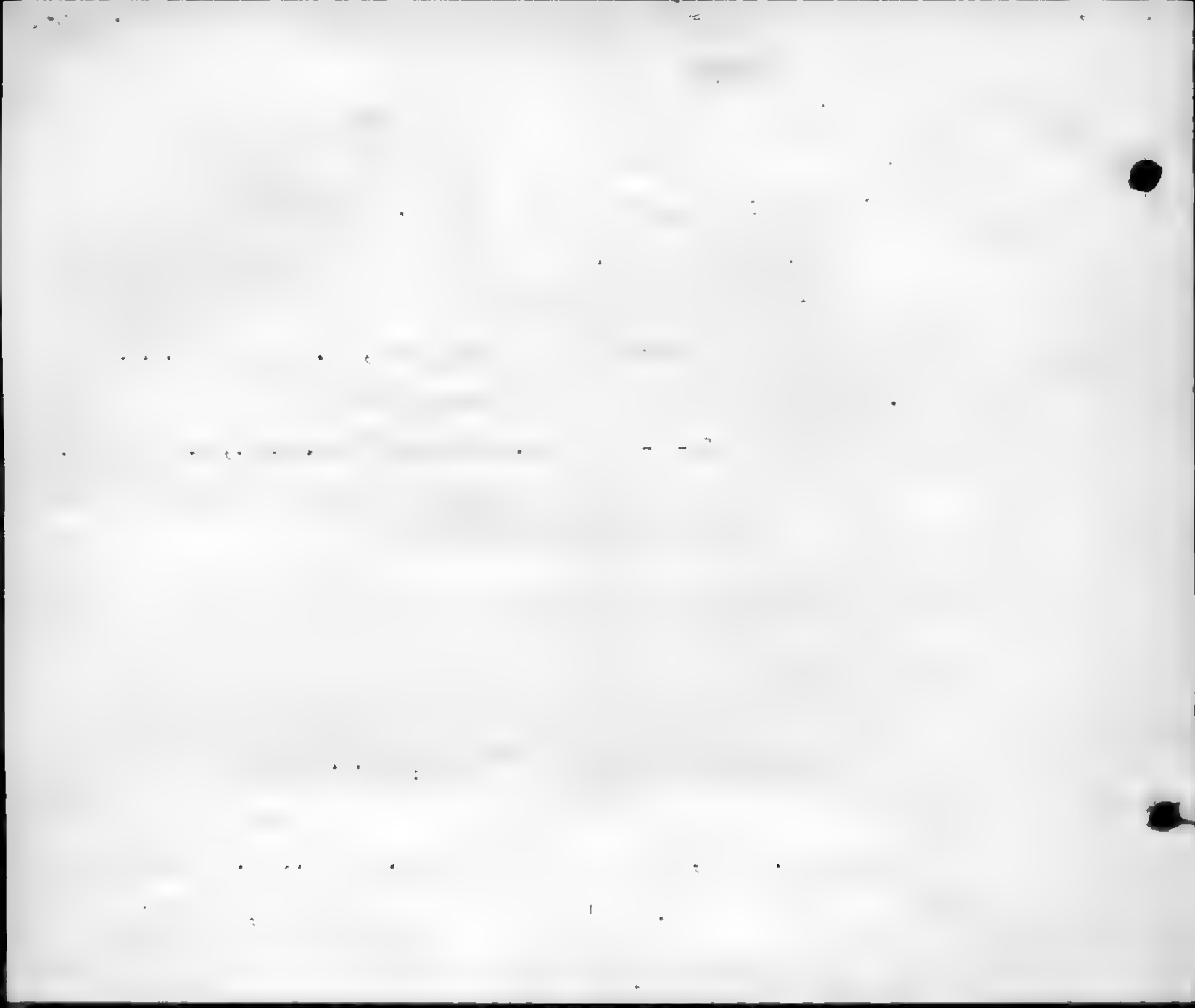
01554

1574

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LLOYD C. BARTGIS</b>		4. DATE OF DEATH Month Day Year <b>February 20 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 12, 1889</b>
9. AGE (In years last birthday) <b>70 yrs</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Huckster</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Produce</b>	
11. BIRTHPLACE (State or foreign country) <b>Myersville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert W. Bartgis</b>		14. MOTHER'S MAIDEN NAME <b>Lydia Blickenstaff</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 220-16-0554</b>	
17. INFORMANT <b>Clin. Records VAH Balto. 18, Md., Ft. Howard Div.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TRANSITIONAL CELL CARCINOMA OF THE RIGHT URETER</b> <b>180X</b> DUE TO <b>WITH WIDESPREAD METASTASES</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c): INTERVAL BETWEEN ONSET AND DEATH <b>9 months</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>February 15 1960</b> to <b>February 20 1960</b> , that <b>1</b> (we) last saw the deceased alive on <b>February 20 60</b> , and that death occurred <b>12:45 A.M.</b> from the causes and on the date stated above			
22a. SIGNATURE <b>Joseph J. Cillo</b> M.D.		22b. DATE SIGNED <b>2/20/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH J. CILLO, MD</b>		22d. ADDRESS <b>VAH Balto. 18, Md., Ft. Howard Division</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-24-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The Elmer C. Fuss Taneytown, Md.</b>		25a. REC'D BY REG STRAR DATE <b>FEB 23 60</b>	
25b. REGISTRAR'S SIGNATURE <b>Collins S. Evans</b>			

FUSS FUNERAL HOME, TANEYTOWN, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1575 CERTIFICATE OF DEATH

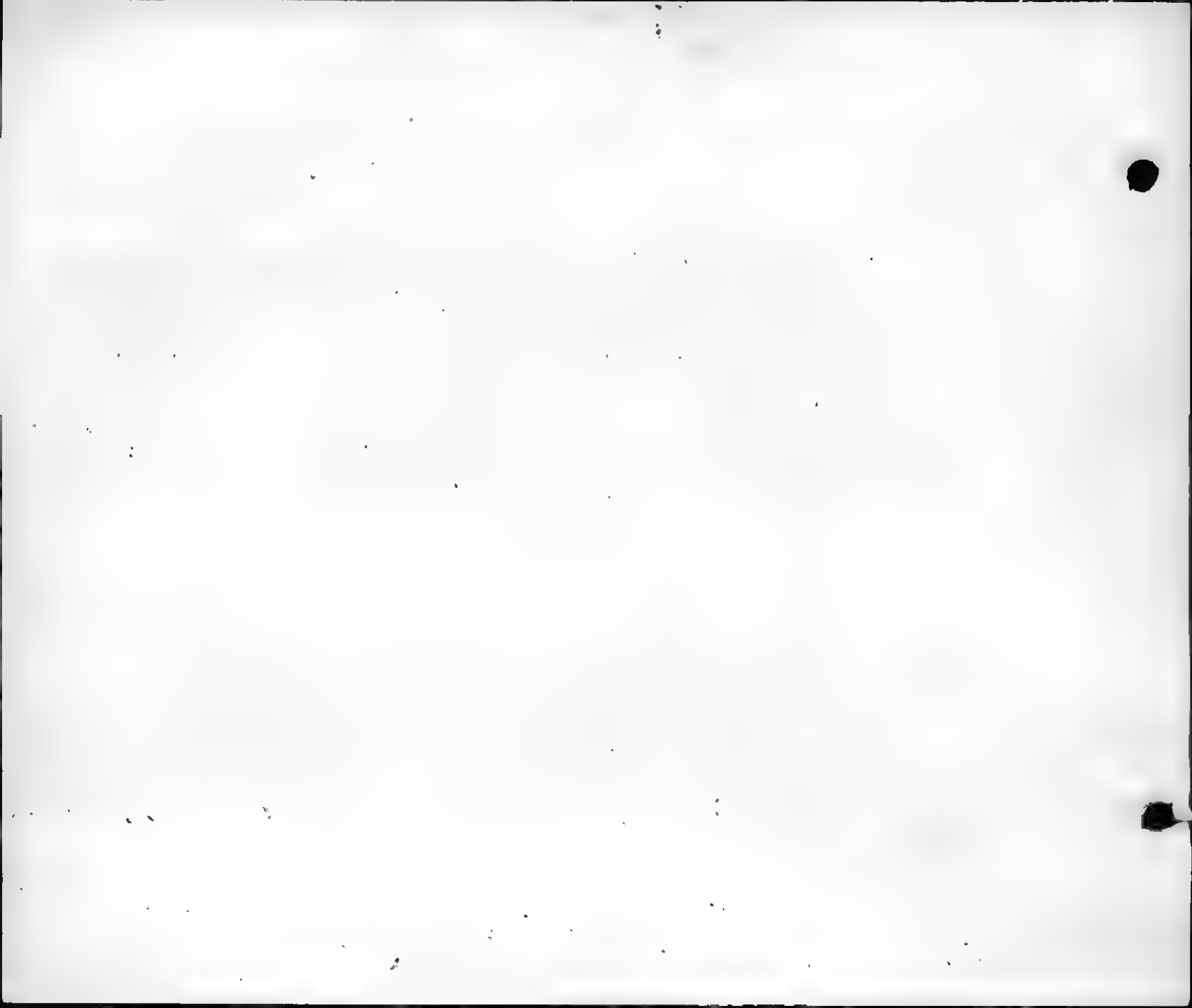
Reg. Dist. No.

02881

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>Loretta</u> Last <u>Batz</u>		4. DATE OF DEATH Month <u>February</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 21, 1897</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pikesv. Movies</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George C. Batz</u>		14. MOTHER'S MAIDEN NAME <u>Loretta L. Dyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO <u>216-03-3151</u>	
17. INFORMANT <u>Mrs. Helen Moser, Doverley Road,</u>		Address <u>Reisterstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 18, 1960</u> , to <u>February 23, 1960</u> , that I last saw the deceased alive on <u>February 18, 1960</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clarence E. McWilliams</u>		ADDRESS (Street, city or town, state) <u>Reisterstown, Maryland</u> DATE SIGNED <u>February 23, 1960</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 26, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Hemmell, Pikesville 8, Md.</u>		24. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 1561 CERTIFICATE OF DEATH

01555

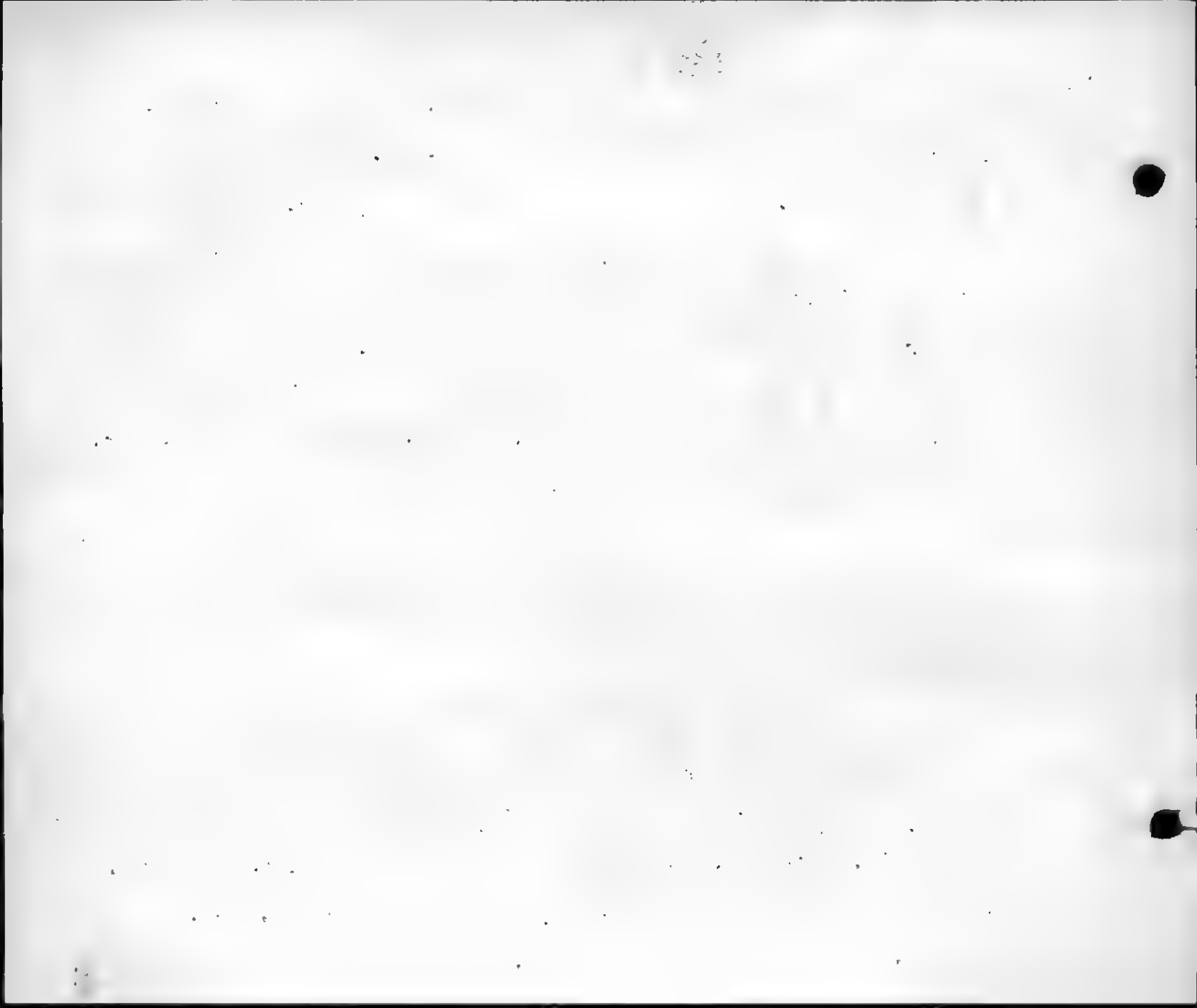
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lansdowne</b> c. LENGTH OF STAY IN TB		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Lansdowne</b> d. STREET ADDRESS <b>358 Bigley Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Lewis</b> Last <b>Baughner</b>		4. DATE OF DEATH Month <b>2</b> Day <b>22</b> Year <b>60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/8/1871</b>
9. AGE (In years last birthday) <b>88</b>		IF UNDER 1 YEAR Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min. <b>88</b>	IF UNDER 24 HRS Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min. <b>88</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frederick Lewis</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann MacFadden</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mrs. Alice Elliott 358 Bigley Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis</b> (c)		INTERVAL BETWEEN ONSET AND DEATH. <b>20 mins.</b> <b>20 yrs.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 1</b> 19 <b>60</b> , to <b>Feb. 22</b> 19 <b>60</b> , that I last saw the deceased alive on <b>Feb. 21</b> 19 <b>60</b> , and that death occurred at <b>8 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Morris W. Steinberg</b>		ADDRESS (Street, city or town, state) <b>3913 Hollins Ferry Rd. Balto., Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Morris W. Steinberg</b>		DATE SIGNED <b>2/22/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/24/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Louder Park Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave. 29</b>	
24a. REC'D BY REGISTRAR <b>FEB 24 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

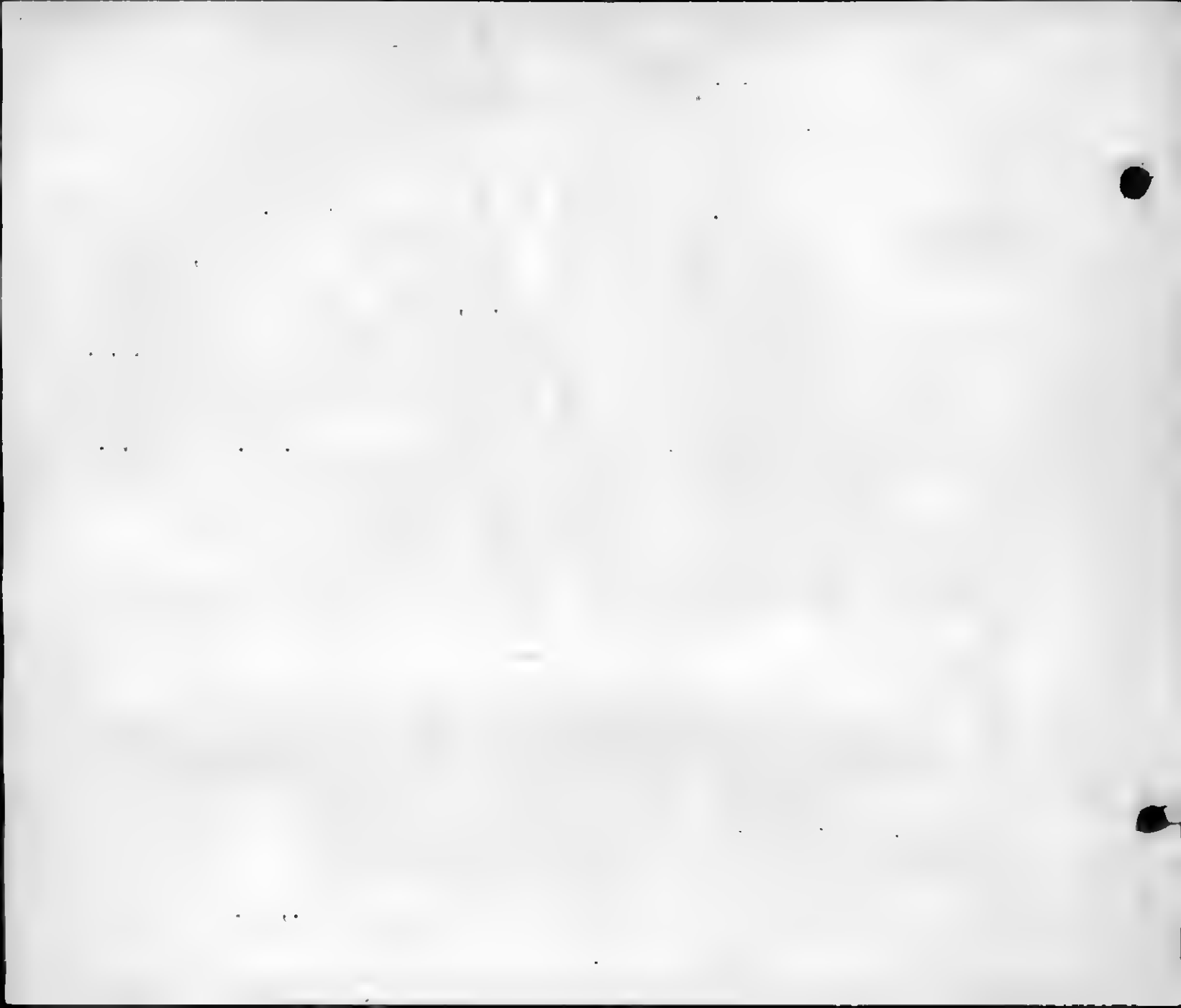
FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

1576

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oliver Beach (20)</b> c. LENGTH OF STAY IN 1b <b>54</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 215 Gunpowder Rd.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oliver Beach (20)</b> d. STREET ADDRESS <b>Box 215 Gunpowder Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY RACHEL BAYMAN</b> First Middle Last		4. DATE OF DEATH <b>February 21,</b> Month Day Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>Nov. 1, 1868</b>
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jobez Oldroyd</b>		14. MOTHER'S MAIDEN NAME <b>Martha Worthington</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>159-18-2886A</b>	
17. INFORMANT <b>William Gee</b>		Address <b>210 Mill Rd. Mt. Holly N.J.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Generalized Carb. Poisoning</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>24 yrs</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Jack P. Collins</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Jack P. Collins</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>2/21/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Phila., Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Bruzdinski</b>		ADDRESS <b>1407 Eastern Ave.</b>	
24a. REC'D BY REGISTRAR <b>FEB 23 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Shirley E. F...</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director or, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

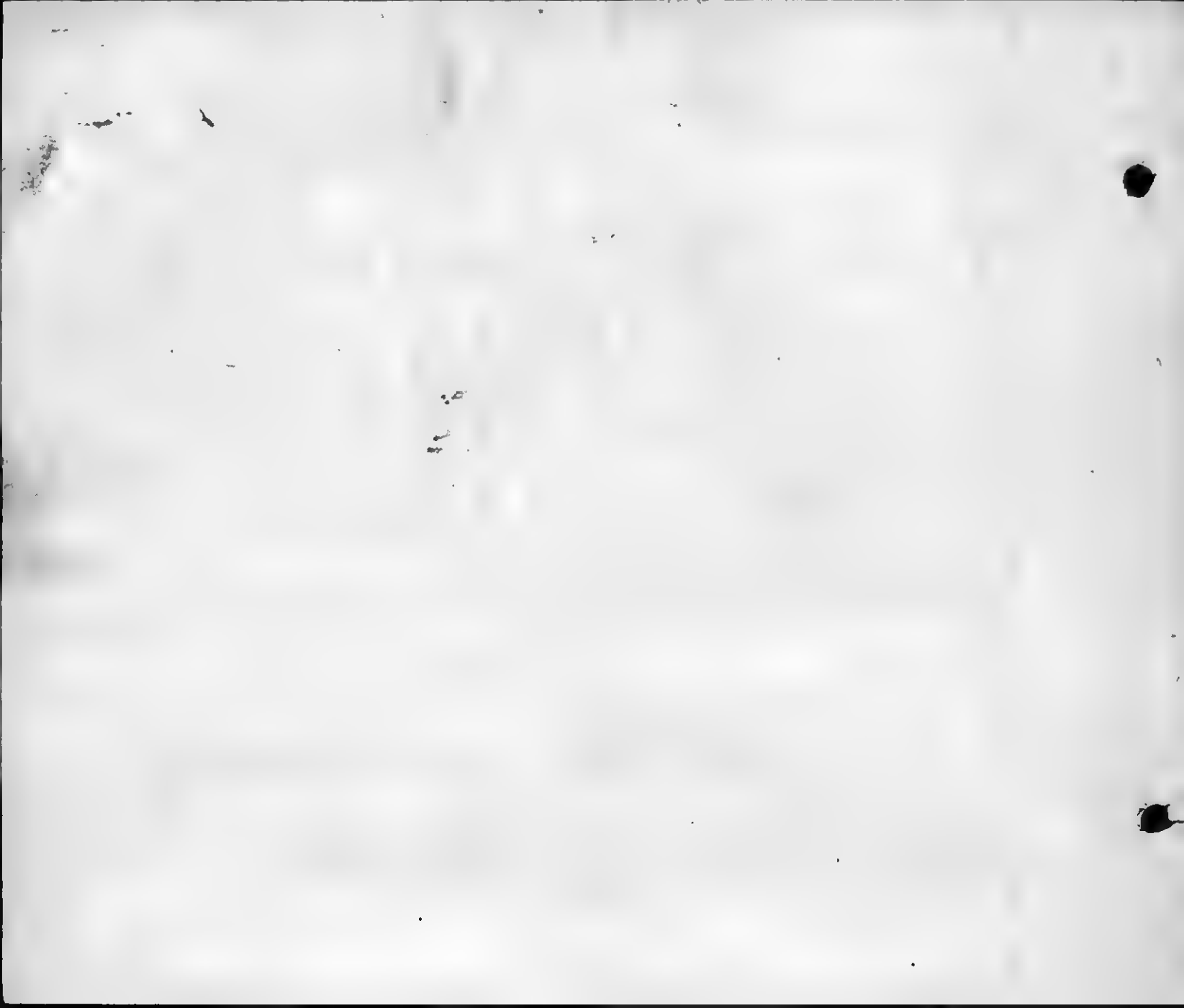
01557

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Balto</u> <u>1577</u> b. CITY OR TOWN (If outside corporate limits, write R.U.A. and give nearest town) <u>Randallstown</u> c. LENGTH OF STAY IN 1b <u>2 wks.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Liberty Road</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Richmond</u> c. CITY OR TOWN (If outside corporate limits, write R.U.A. and give nearest town) <u>Manassfield</u> d. STREET ADDRESS <u>1822 Woodville Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>VERNON (WEALKER) BEALL</u> First <u>VERNON</u> Last <u>BEALL</u>		<b>4. DATE OF DEATH</b> Month <u>Feb</u> Day <u>20</u> Year <u>1960</u>			
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Dec 15, 1903</u>		
<b>9. AGE</b> (in years last birthday) <u>56 yrs.</u>	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Store Rm. Clerk</u>	<b>11. BIRTHPLACE</b> (State or foreign country) <u>Cumberland, Md.</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>Levington W. Beall</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Smith</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO</b> <u>217-10-5048</u>			
<b>17. INFORMANT</b> <u>Unlabeled Lee Rizer - Randallstown</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Diabetes</u> (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>4 yrs</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. EXTERNAL CAUSE</b> PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>none</u>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) <u>none</u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>none</u> p. m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>none</u>	<b>20f. (City or town)</b> <u>none</u>	<b>(County)</b> <u>none</u>	<b>(State)</b> <u>none</u>
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></b>					
<b>ACTUAL SIGNATURE</b> <u>D.D. Caples</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <u>2-20-60</u>	
<b>EXAMINER'S NAME (Type)</b> <u>D.D. CAPLES</u>		<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>			
<b>22b. DATE THEREOF</b> <u>2/23/60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Glendale Brethren Cem.</u>		<b>22d. LOCATION (City, town, or county)</b> <u>Flintstone, Maryland</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John J. Hafer, Cumberland, Maryland</u>		<b>24a. REC'D BY REGISTRAR</b> DATE <u>FEB 24 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director or, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 1578 CERTIFICATE OF DEATH

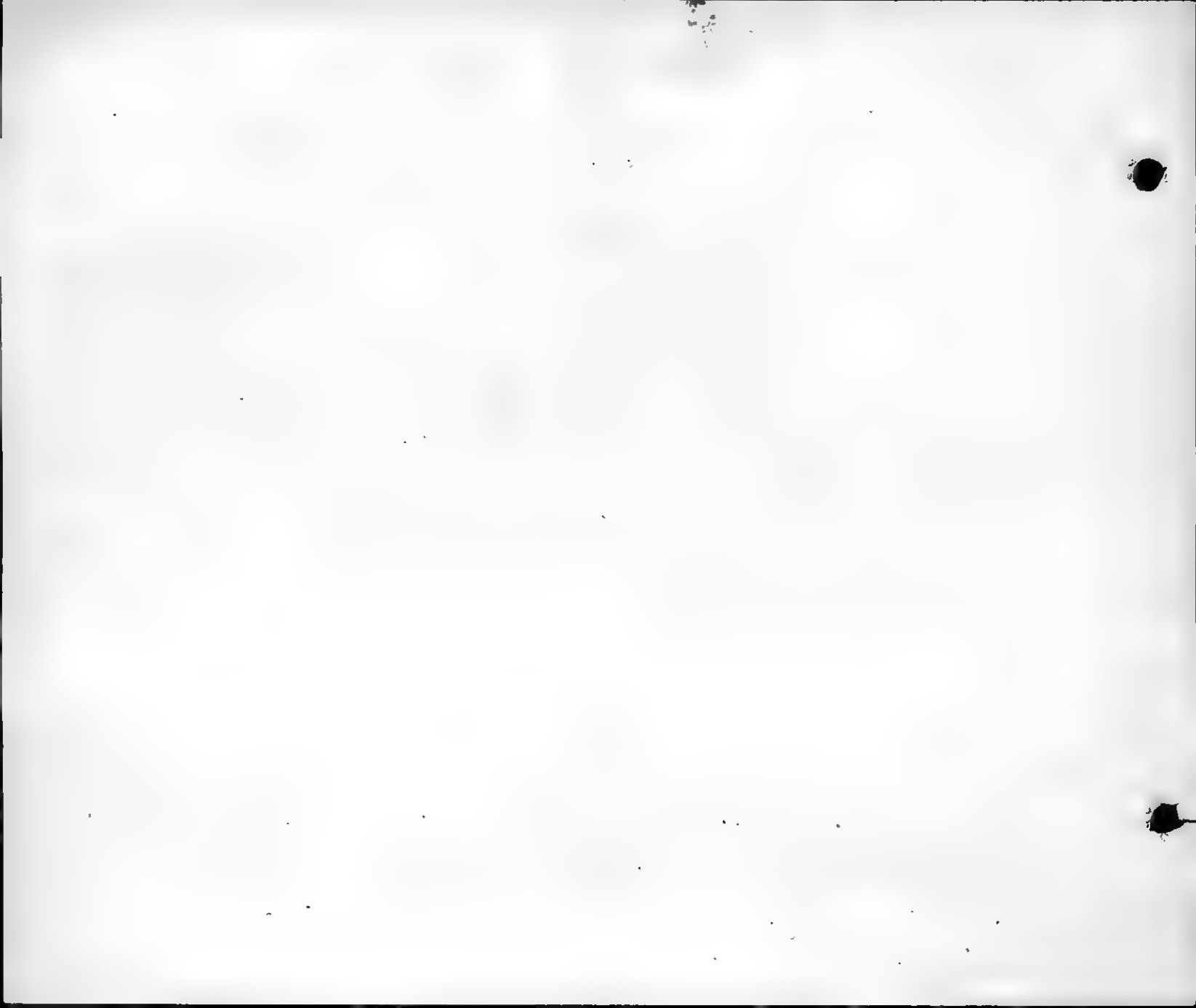
Reg. Dist. No.

01558

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on: Residence before admision) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>6 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1 Bishops LANE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CAROLINE</u> Middle <u>P.</u> Last <u>BELL</u>		4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 21, 1884</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>2</u> Hours <u>15</u> Min.	11. IF UNDER 24 HRS Months <u>7</u> Days <u>2</u> Hours <u>15</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING Mfg.</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John TILLER</u>		14. MOTHER'S MAIDEN NAME <u>BARBARA SALLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>4 1</u>	
17. INFORMANT <u>MRS WESLEY OREM</u>		Address <u>1 Bishops LANE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>scabites mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1940</u> , 19 <u>  </u> , to <u>2-22-</u> 19 <u>60</u> , that I last saw the deceased alive on <u>2-22-</u> 19 <u>60</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Morris B. Schreiber</u> M.D.		ADDRESS (Street, city or town, state) <u>54 S. F. N. Ave</u> DATE SIGNED <u>2-23-60</u>	
PHYSICIAN'S NAME (Type) <u>MORRIS B. SCHREIBER</u>		<u>Baltimore Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/25/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. L. Schwab</u> ADDRESS <u>Francis W. Miller 2101 Fredrick Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 1579 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>55</b> <b>Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>221 Rogers Forge Rd.</b>		d. STREET ADDRESS <b>221 Rogers Forge Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Hollis</b> Middle <b>F.</b> Last <b>Bennett</b>		4. DATE OF DEATH Month <b>2</b> Day <b>9</b> Year <b>1960</b>	
5. SEX <b>m</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-27-1887</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b></b> Days <b></b>	11. IF UNDER 24 HRS Hours <b></b> Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Metals</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Cleophus E. Bennett</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Collison</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>213-05-4160</b>	
17. INFORMANT <b>Mrs. Louise C. Bennett</b>		Address <b>Above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>Gen. Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1958</b> <b>8-8-59</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-4-1958</b> to <b>2-9-1960</b> , that I last saw the deceased alive on <b>2-9-1960</b> , and that death occurred on <b>5:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert H. Siver</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>3105 N. Charles St. Baltimore, Md. 2-10-60</b>	
PHYSICIAN'S NAME (Type) <b>R.H. Siver</b>		<b>Baltimore, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>2-11-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co.</b>		24a. REC'D BY REGISTRAR <b>4905 York Rd. Baltimore-12, Md.</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>		DATE <b>FEB 15 '60</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



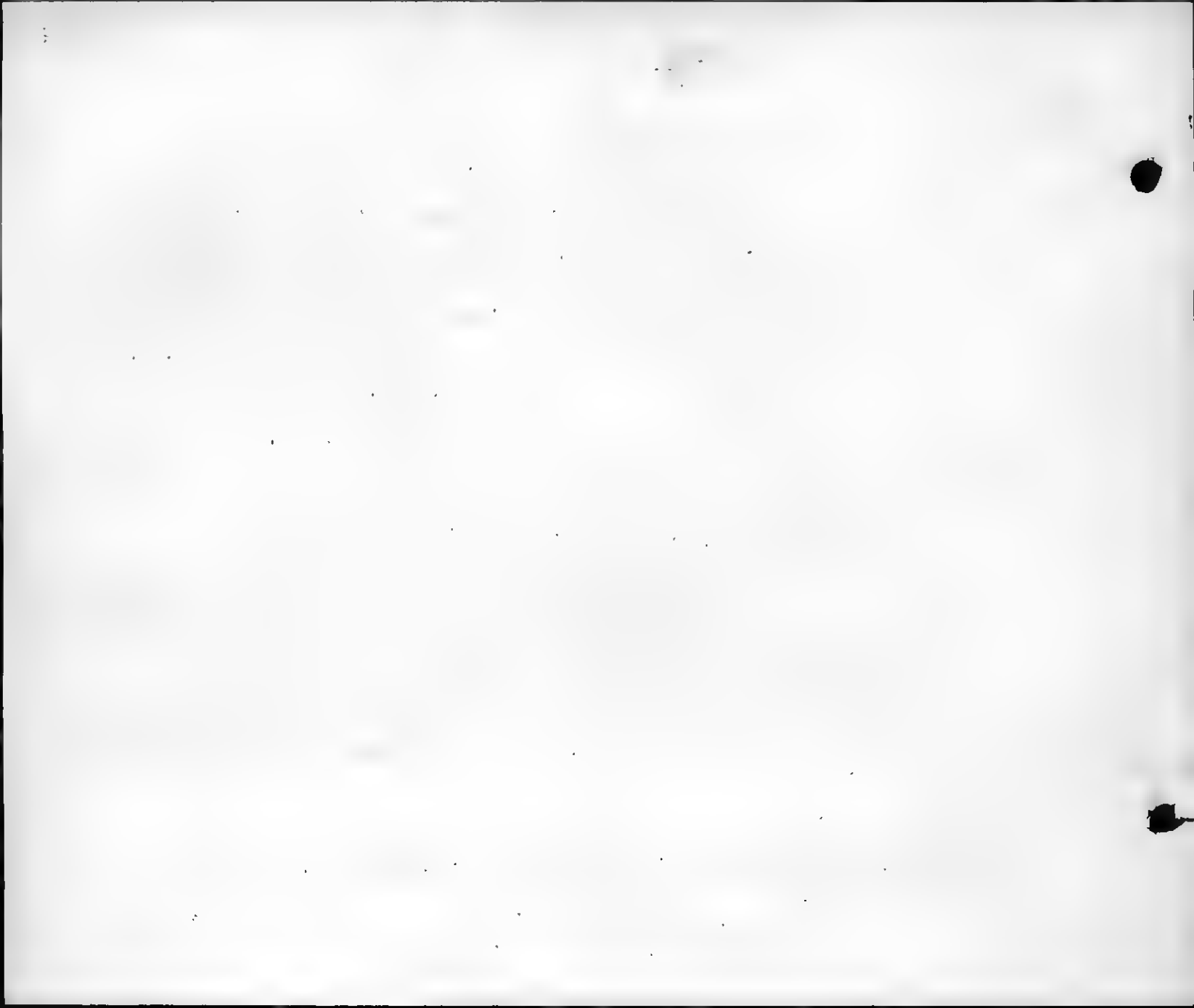
## 1580 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>6yr10mth28dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>3711 West Strathmore Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle Last <b>Bercowitz</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>2</b> Year <b>1960</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec., 1906</b>	
9. AGE (In years last birthday) <b>53</b> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Abraham Bercowitz</b>				14. MOTHER'S MAIDEN NAME <b>Rachael Edelberg</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Unknown</b>			
INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Arterioscl. General, severe</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan. 10, 1960</b> to <b>FEB. 2, 1960</b> , that I last saw the deceased alive on <b>FEB 2, 1960</b> , and that death occurred at <b>5:45 PM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D. <b>SPRING GROVE STATE HOSPITAL</b>							
PHYSICIAN'S NAME (Type) <b>STELLA WACHSLER</b> <b>Catonsville 28, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL, (Specify)							
22b. DATE THEREOF <b>2/5/60</b>							
22c. NAME OF CEMETERY OR CREMATORY <b>Baldwin</b>							
22d. LOCATION (City, town, or county) (State) <b>Baldwin, Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>6010 Pennsylvania Rd.</b>							
24a. REC'D BY REGISTRAR DATE <b>FEB 8 '60</b>							
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Travis</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

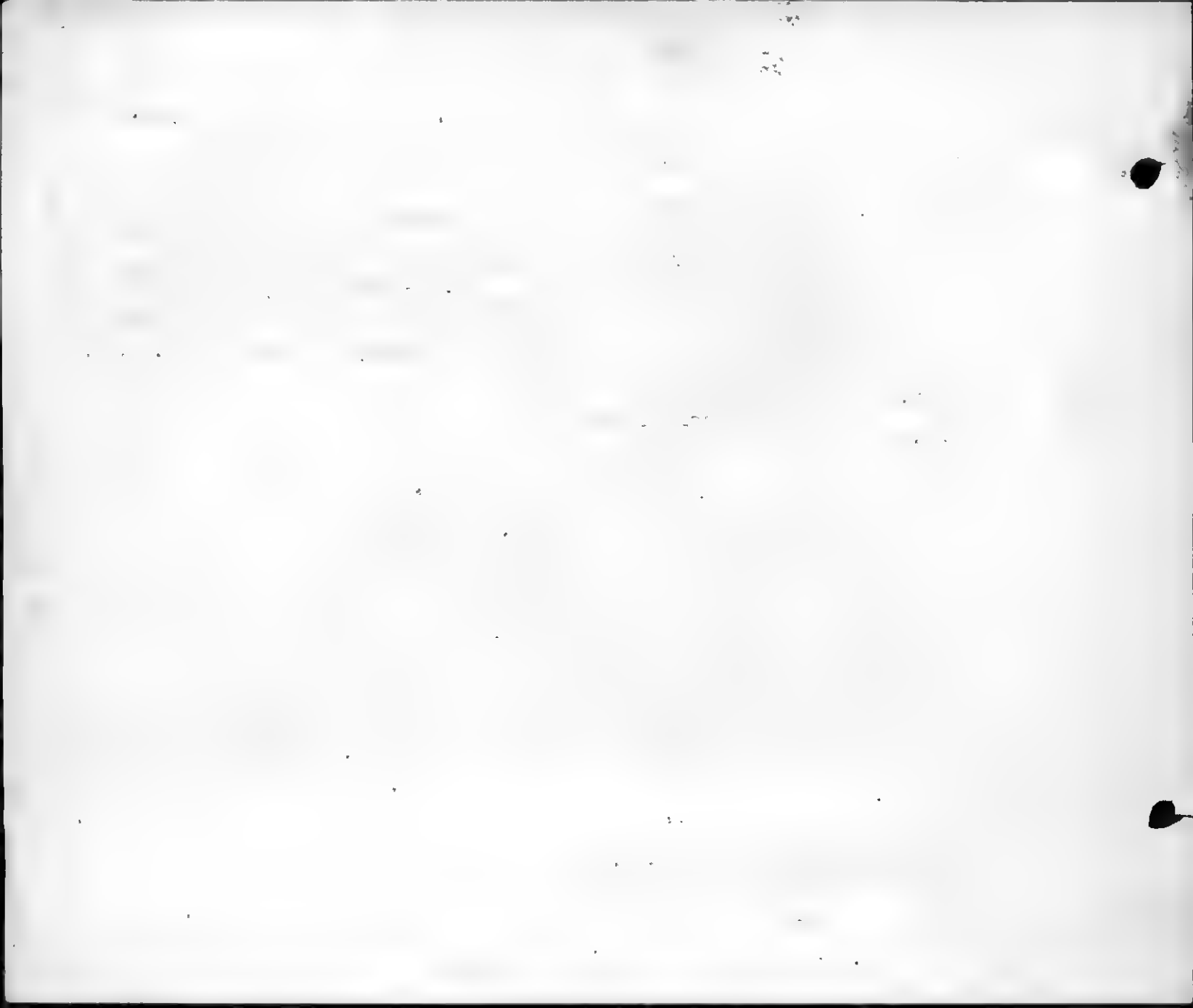
may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1581 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1 year 3m, 6 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ola</b> Middle <b>May</b> Last <b>Biddinger</b>		4. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-12-1886</b> <b>1885 XXXXX</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Unknown Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Abraham Rickmond</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 422.1 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 28, 1958</b> to <b>Feb. 3, 1960</b> , that I last saw the deceased alive on <b>Feb. 3, 1960</b> , and that death occurred at <b>10:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Stella Wachsler M.D. SPRING GROVE STATE HOSPITAL 2-4-60</b>			
ACTUAL SIGNATURE <b>Stella Wachsler</b>		PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-6-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>		22d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Frank</b>		24. REC'D BY REGISTRAR DATE <b>FEB 9 '60</b>	





## 1582 CERTIFICATE OF DEATH

Reg. Dist. No. 32

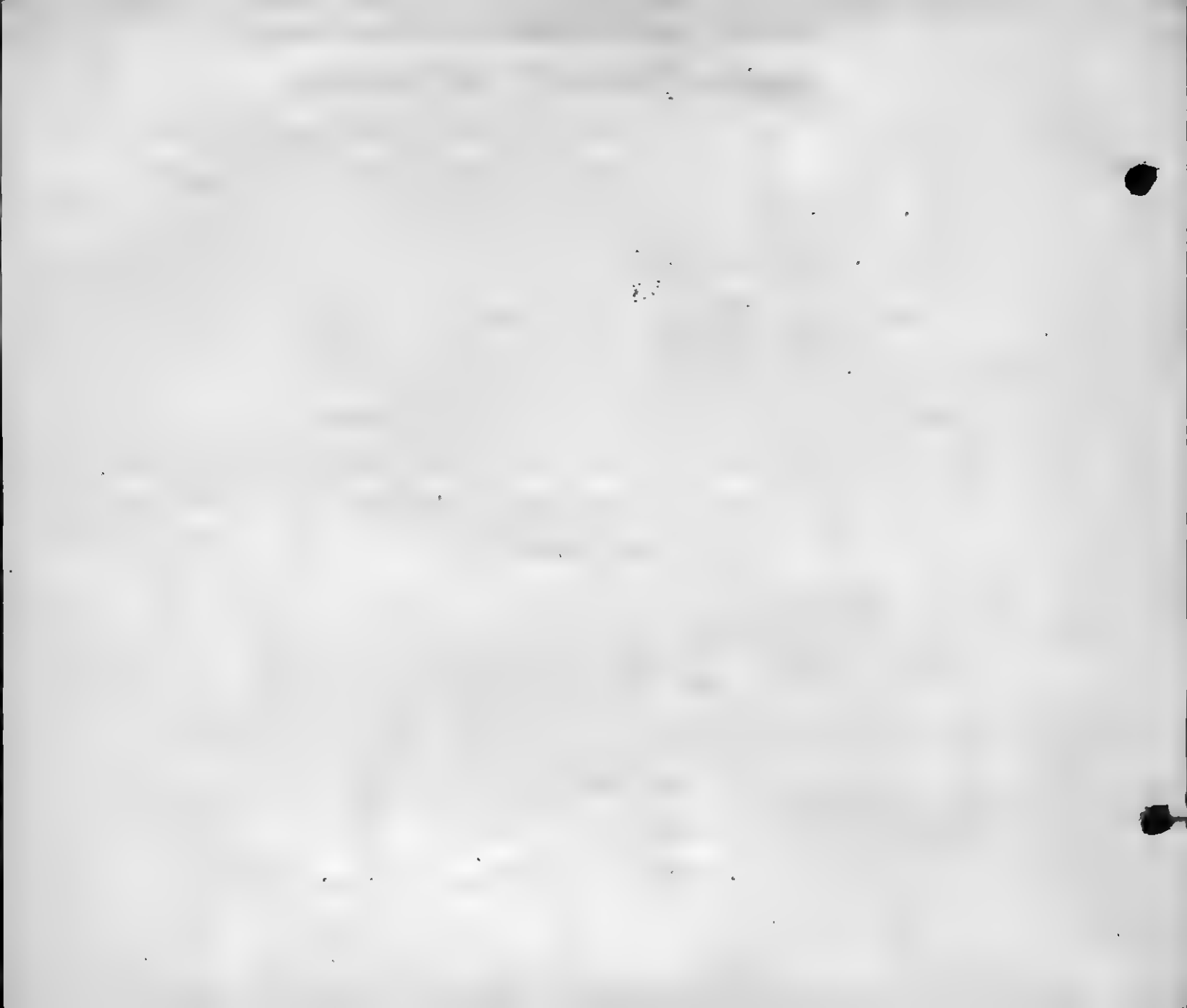
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore County</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Balt.</u> City <u>City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mt. Wilson, Maryland</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>22 S. Athol Ave.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Harry Lee Billmyer</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 15 1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>3/3/73</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumbing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>building</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Oliver Billmyer</u>				14. MOTHER'S MAIDEN NAME <u>Frances Lavenia</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>none 220-30-2872A</u>		17. INFORMANT & ADDRESS <u>Hospital Records, Mt. Wilson State Hospital</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				4 days			
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>				15 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pulmonary tuberculosis</u>				3 years			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/9/57</u> , 19 <u>57</u> , to <u>2/15/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/15/60</u> , 19 <u>60</u> , and that death occurred at <u>4:50 PM</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Wm. Newcomer, M.D. Superintendent, Mt. Wilson, Maryland</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>FEB. 18/60</u>		NAME OF CEMETERY OR CREMATORY <u>LODDON PARK</u>		LOCATION (City, town, or county) (State) <u>BALTO, MD.</u>	
24. REC'D BY REGISTRAR DATE <u>FEB 17 '60</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. K. Funeral Dir. EDMONDSON AVE.</u>		ADDRESS <u>4101</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104



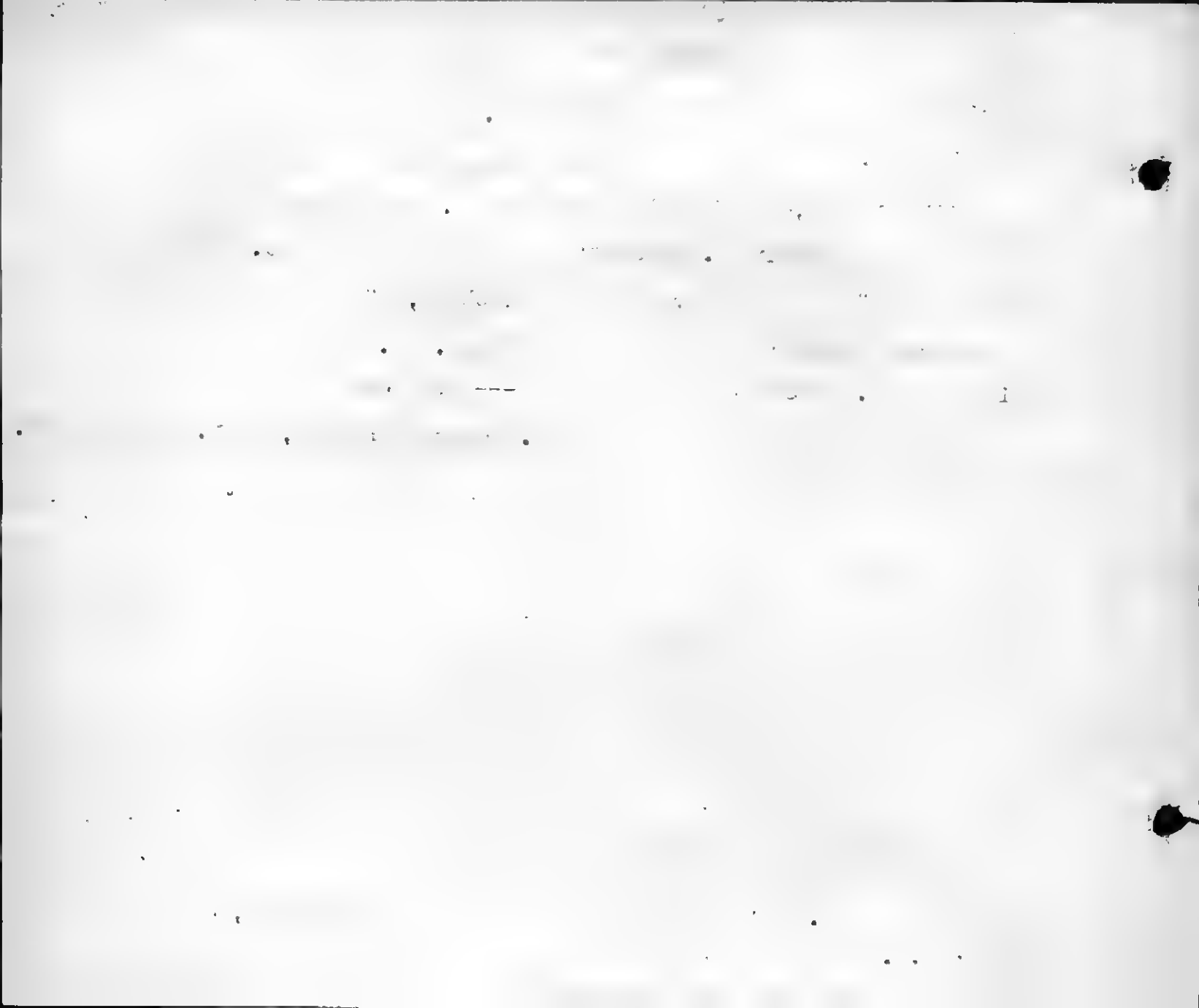
## 1583 CERTIFICATE OF DEATH

Reg. Dist. No. 01563

1. PLACE OF DEATH COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Villa Nova</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Augsburg Home, 6811 Campfield Rd</b>		d. STREET ADDRESS <b>639 N. Augusta Ave</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Richard T. Birchett</b>		4. DATE OF DEATH Month Day Year <b>Feb. 6/60</b> 19	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 13, 1872</b>
9. AGE (In years last birthday) <b>87 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret red) <b>Retired Butcher</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Balte. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Richard T. Birchett</b>		14. MOTHER'S MAIDEN NAME <b>Barringer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO	
INFORMANT <b>Mrs. George Forsythe, 619 N. Augusta Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>481X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <b>(1) - Anterior Sclerotic Heart Disease</b> <b>(2) - Influenza</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arterio-sclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March - 3, 1959</b> to <b>Feb. 6, 1960</b> , that I last saw the deceased alive on <b>Feb. 5, 1960</b> , and that death occurred at <b>4 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Earl L. Chambers</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>4108 Liberty St. Balto - 7-Inf 26-60</b>	
PHYSICIAN'S NAME (Type) <b>Earl L. Chambers</b>		<b>4108 Liberty Ave. Balto - 7-Inf.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 8/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F.D., 4101 Edmondson Ave</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 11 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hearn</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 1531 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b <u>144</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>108 KING CT</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Black</u> Last <u>Black</u>		4. DATE OF DEATH Month <u>February</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FFB-15-99</u>
9. AGE (In years last birthday) <u>60</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>11</u> Days <u>5</u> Hours <u>-</u> Min <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas &amp; Electric</u>	
11. BIRTHPLACE (State or foreign country) <u>Fairfield S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Andy Black</u>		14. MOTHER'S MAIDEN NAME <u>Mary Thicker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-05-7354</u>	
17. INFORMANT <u>MARIE OWENS</u>		Address <u>14318 Sager St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Nephritis</u> DUE TO (c) <u>Cardio-vascular Disease (Arteriosclerosis)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>45 hr.</u> <u>2 MONTHS</u> <u>1 YEAR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 4, 1948</u> , to <u>FEB 10, 1960</u> , that I last saw the deceased alive on <u>FEBRUARY 10, 1960</u> , and that death occurred at <u>7:35</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Wade</u> M.D.		ADDRESS (Street, city or town, state) <u>140 Oak Ave</u> DATE SIGNED <u>2-10-60</u>	
PHYSICIAN'S NAME (Type) <u>William C. Wade, M.D.</u>		<u>Dundalk 22, Md</u>	
22a. BURIAL, CREATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>2/13/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas C. Wilson</u> ADDRESS <u>1000 Brantley Ave</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 15 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Clifford S. Knaus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

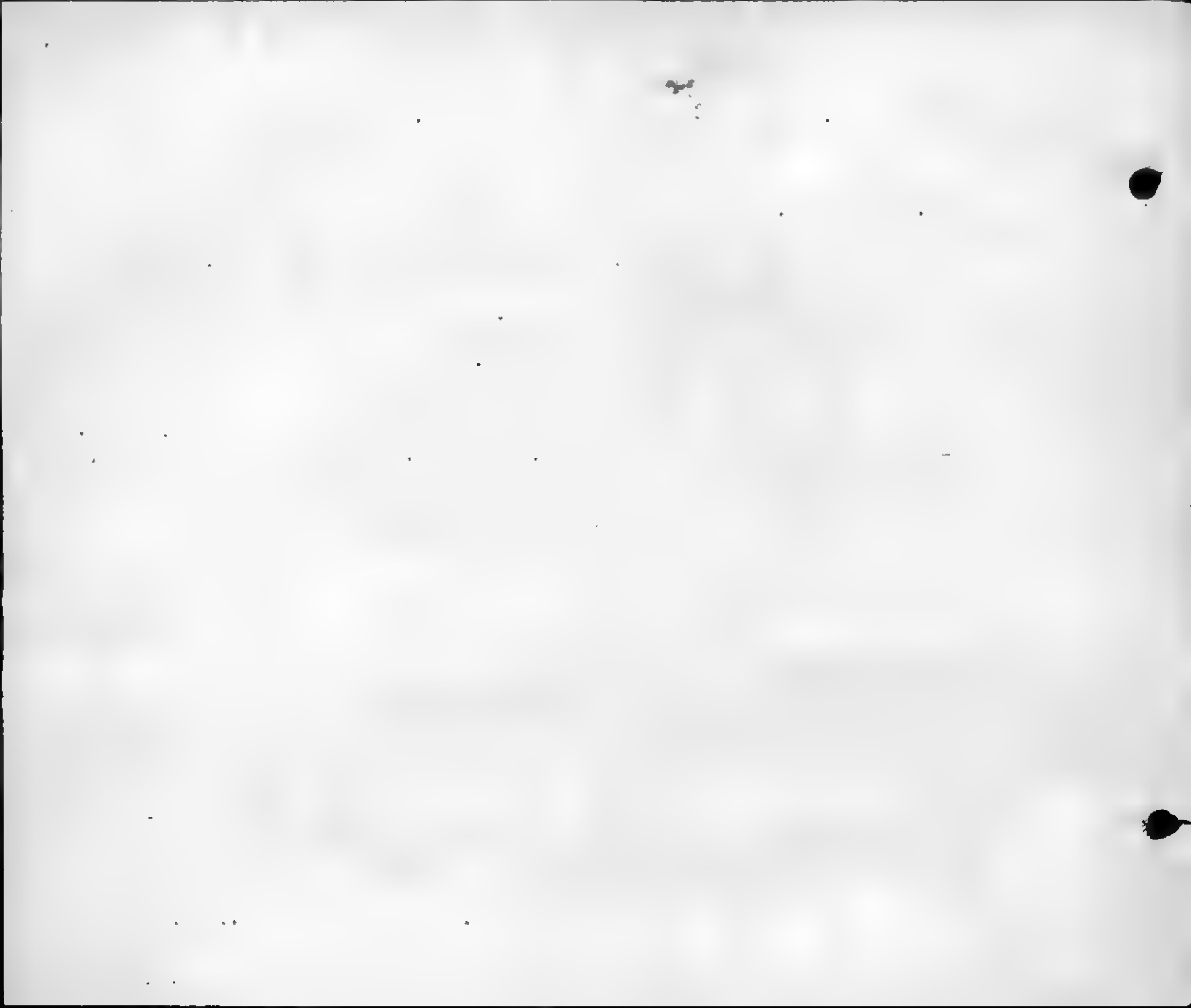
1584 CERTIFICATE OF DEATH

01565

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>1</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8 S. Rolling Rd. (At home)</b>		d. STREET ADDRESS <b>Dixon Hill</b>	
3. NAME OF DECEASED (Type or print) First <b>HILDA</b> Middle <b>S.</b> Last <b>BOOZE</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>20</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 14, 1893</b>
9. AGE (In years last birthday) <b>66</b> yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles Steinbach</b>		14. MOTHER'S MAIDEN NAME <b>Mary Reinhardt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. William C. Booze - 906 Locustvale Rd.</b>		Address <b>Towson, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of rectum with metastases</b> 154 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>Nov '57</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5 Feb</b> , 1960, to <b>20 Feb</b> , 1960, that I last saw the deceased alive on <b>20 Feb</b> , 1960, and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1118 St Paul St, Baltimore 2, Md.</b> DATE SIGNED <b>2-22-60</b>			
ACTUAL SIGNATURE <b>John A. Nesbitt, Jr.</b>		M. D. <b>1118 St Paul St, Baltimore 2, Md.</b>	
PHYSICIAN'S NAME (Type) <b>JOHN A. NESBITT, JR.</b>		<b>Baltimore 2, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/23/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Fisher - Mrs Baltimore, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 24 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1585 CERTIFICATE OF DEATH

01566

Reg. Dist. No.

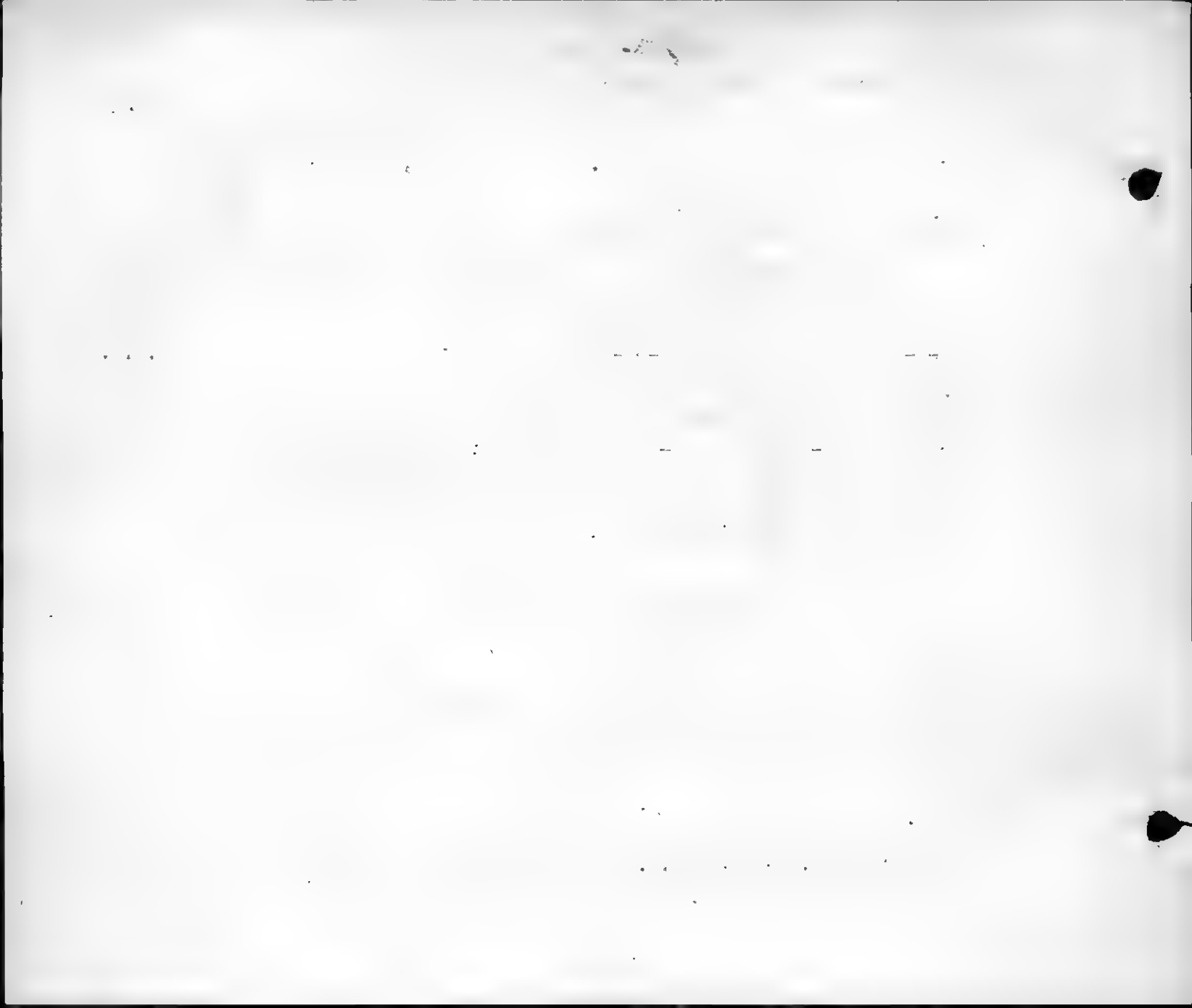
1. PLACE OF DEATH <u>Rosewood State Training School</u>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) <input checked="" type="checkbox"/>			
a. COUNTY <u>Baltimore</u> MARYLAND				b. COUNTY <u>Worcester</u> Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill, Maryland</u>			
c. LENGTH OF STAY IN Td <u>4 years.</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
		<u>Georgianna</u>				<u>Bowen</u>	
4. DATE OF DEATH		Month		Day		Year	
		<u>2</u>		<u>1</u>		<u>19 60</u>	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS
<u>Female</u>	<u>Negro</u>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<u>1909</u>		<u>51</u>	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country)		12 CITIZEN OF WHAT COUNTRY?	
				<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Jim Bowen</u>				<u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address	
<u>no</u>				<u>Rosewood Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>							<u>4 hours</u>
490X DUE TO <u>Pneumonia, lobar</u>							<u>4 days</u>
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour o. m. p. m. <u>19</u>		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
21. I certify that I attended the deceased from <u>1/10/56</u> , 19__, to <u>2/1/60</u> , 19__, that I last saw the deceased alive on <u>2/1/60</u> , 19__, and that death occurred at <u>8:30p</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Edward J. Mathews</u> M.D.				<u>Rosewood State Training School</u> <u>2/5/60</u>			
PHYSICIAN'S NAME (Type) <u>Edward J. Mathews, M.D.</u>				<u>Owings Mills, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>2 - 5 - 20</u>		<u>2 - 5 - 20</u>		<u>St. Mary's Cemetery</u>		<u>Baltimore, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>Frank H. Newell / Baltimore</u>				DATE <u>FEB 18 '60</u>		<u>John S. Kane</u>	

Page 4 death hours

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**1586 CERTIFICATE OF DEATH**

01567

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE <u>Ind.</u> b. COUNTY <u>Balto.</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edwardsville</u>				c. LENGTH OF STAY IN 1b <u>X Higwood Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Body with for home</u>				d. STREET ADDRESS <u>Woodlawn 7</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Adelaide S. Bowers</u>				4. DATE OF DEATH Month Day Year <u>Feb. 17 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/30/84</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Geo. Schuman</u>				14. MOTHER'S MAIDEN NAME <u>Sophie Meier</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Ethel Wahans</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Influenza</u> 481X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>1 yr +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paralysis agitans</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> 19 <u>Feb 17</u> 1960, that (I) (we) last saw the deceased alive on <u>Feb 16</u> 1960, and that death occurred at <u>12:10</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>John A. Nesbitt Jr.</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT, JR</u>				22d. ADDRESS <u>1118 St Paul St., Baltimore 2, Ind.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/20/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. Ind.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Nesbitt Jr.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur J. King</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1587 CERTIFICATE OF DEATH

01568

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balk</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>45 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Alverta</u> Last <u>Bowersox</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 29, 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>79</u>
11. BIRTHPLACE (State or foreign country) <u>Adams County, Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Eckenrode</u>		14. MOTHER'S MAIDEN NAME <u>Marica</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		17. INFORMANT <u>Orma Bowersox</u> Address <u>Pikesville 8, Md.</u>	
16. SOCIAL SECURITY NO <u>None</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis C.V.D.</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>Ulcers of legs</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>p. m.</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 17</u> , 19 <u>60</u> , to <u>Feb 14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 17</u> , 19 <u>60</u> , and that death occurred at <u>0155 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1632 Reisterstown Road</u> DATE SIGNED ACTUAL SIGNATURE <u>Charles H Williams</u> M.D. PHYSICIAN'S NAME (Type) <u>Charles H Williams, M.D.</u> <u>Pikesville 8, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>buried</u>	<u>Feb. 15, 1960</u>	<u>St. Agnes Cemetery</u>	<u>Pikesville 8, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank St. James</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 18 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1562

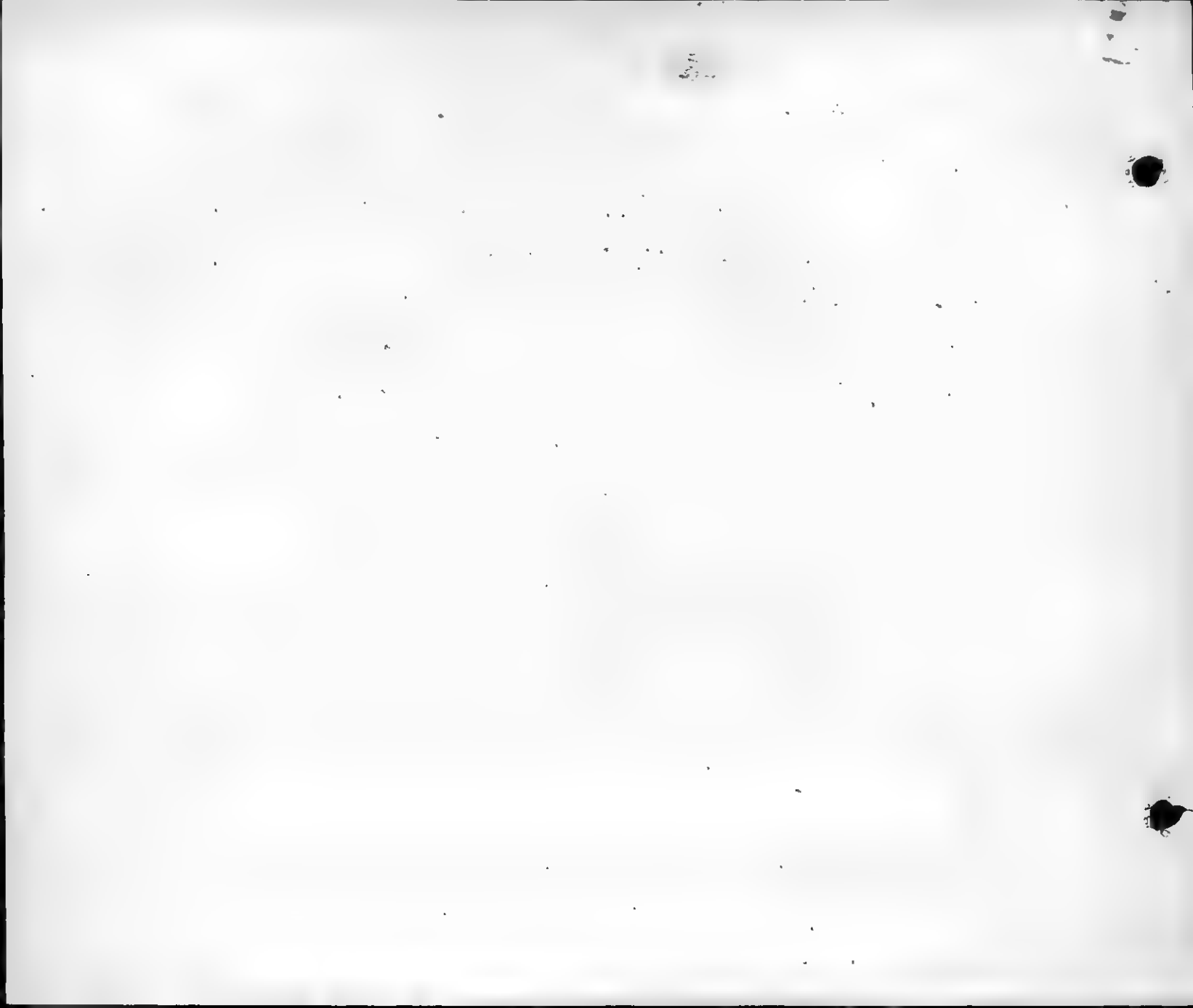
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arbutus</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4147 Linden Ave.</i>		d. STREET ADDRESS <i>4015 Washington St.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Annabelle Elizabeth Boyd</i>		4. DATE OF DEATH Month Day Year <i>Feb. 5 19 60</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-18-1900</i>
9. AGE (In years last birthday) yrs. <i>60</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Mark R. Scholl</i>		14. MOTHER'S MAIDEN NAME <i>Katherine E. Stitze</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
INFORMANT <i>Howard Boyd</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute cardiac dilatation</i>			
444 * DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
(b) <i>Renal cardio vascular disease</i>			
(c) <i>hypertension</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>15 yrs.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May</i> , 19 <i>40</i> , to <i>Feb. 5</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Feb. 4</i> , 19 <i>60</i> , and that death occurred at <i>4:30 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Alcaias</i>		M.D. <i>4 N Fulton Ave. Balt. Md.</i>	
PHYSICIAN'S NAME (Type) <i>Alcaias</i>		DATE <i>2/6/60</i>	
22a. BURIAL, CREMATON, REMOVAL (Specify)	22b. DATE THEREOF <i>2/9/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>PARKWOOD Cem</i>	22d. LOCATION (City, town, or county) (State) <i>BAITO Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Rd</i>	
24a. REC'D BY REGISTRAR DATE <i>FEB 9 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

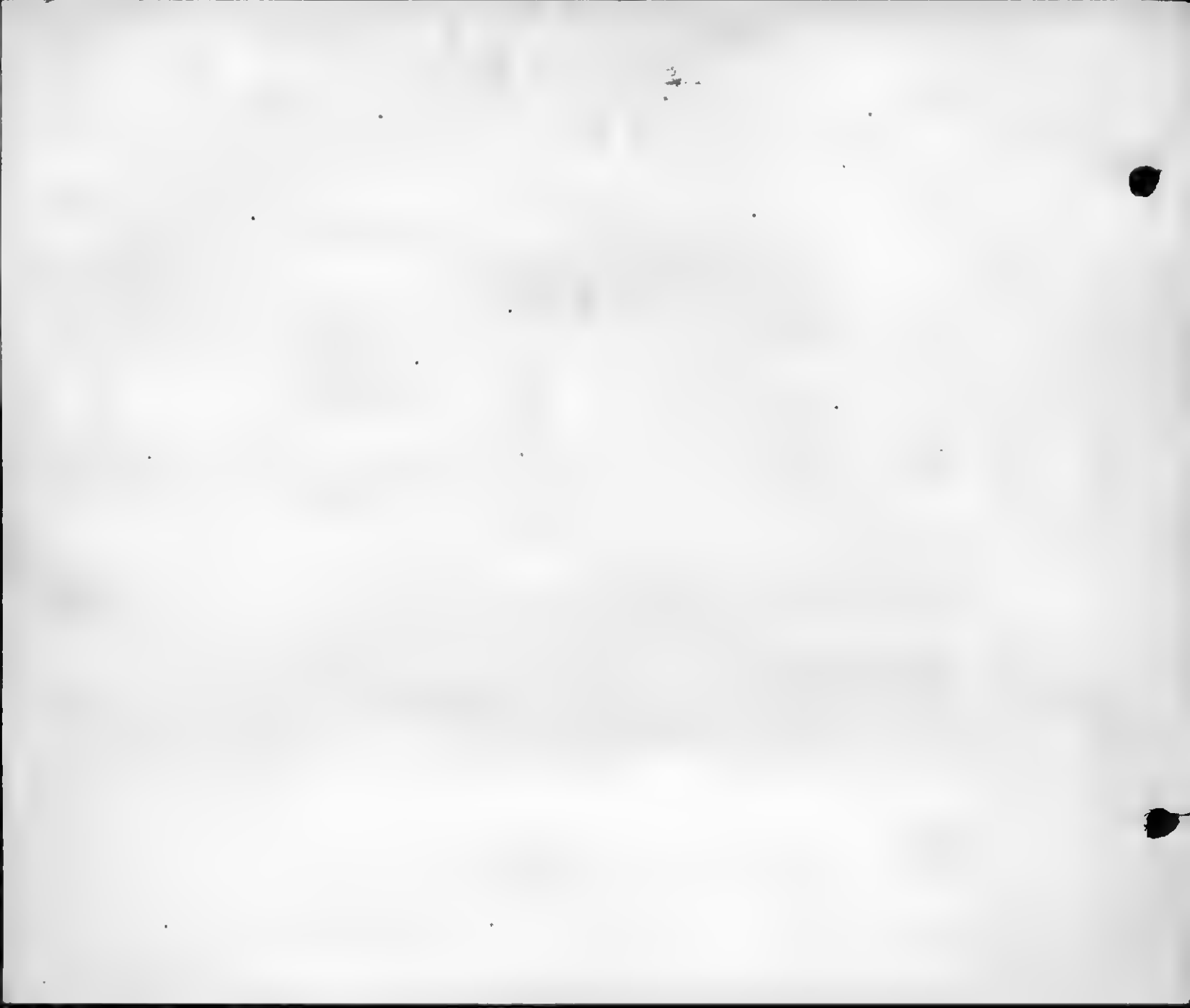
1588

## CERTIFICATE OF DEATH

01570

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaywood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaywood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6814 Blenheim Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HESTER</u> Middle <u>HILL</u> Last <u>BOYER</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>13</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 19, 1883</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>Charles S. Hill</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Sparks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO <u>  </u>	
17. INFORMANT <u>Mrs. George Bullard - 50 Dunkirk Rd.</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>170X Cancer of the breast</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>12-31, 1959</u> to <u>2-12, 1960</u> , that I last saw the deceased alive on <u>2-12, 1960</u> , and that death occurred at <u>12:54 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William G. Helfrich</u>		ADDRESS (Street, city or town, state) <u>5006 Roscoe Ave</u>	
PHYSICIAN'S NAME (Type) <u>Balto 10, Maryland</u>		DATE SIGNED <u>2-14-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/15/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner 4 hours - Balto 17 Md</u>		ADDRESS <u>  </u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinner</u>	



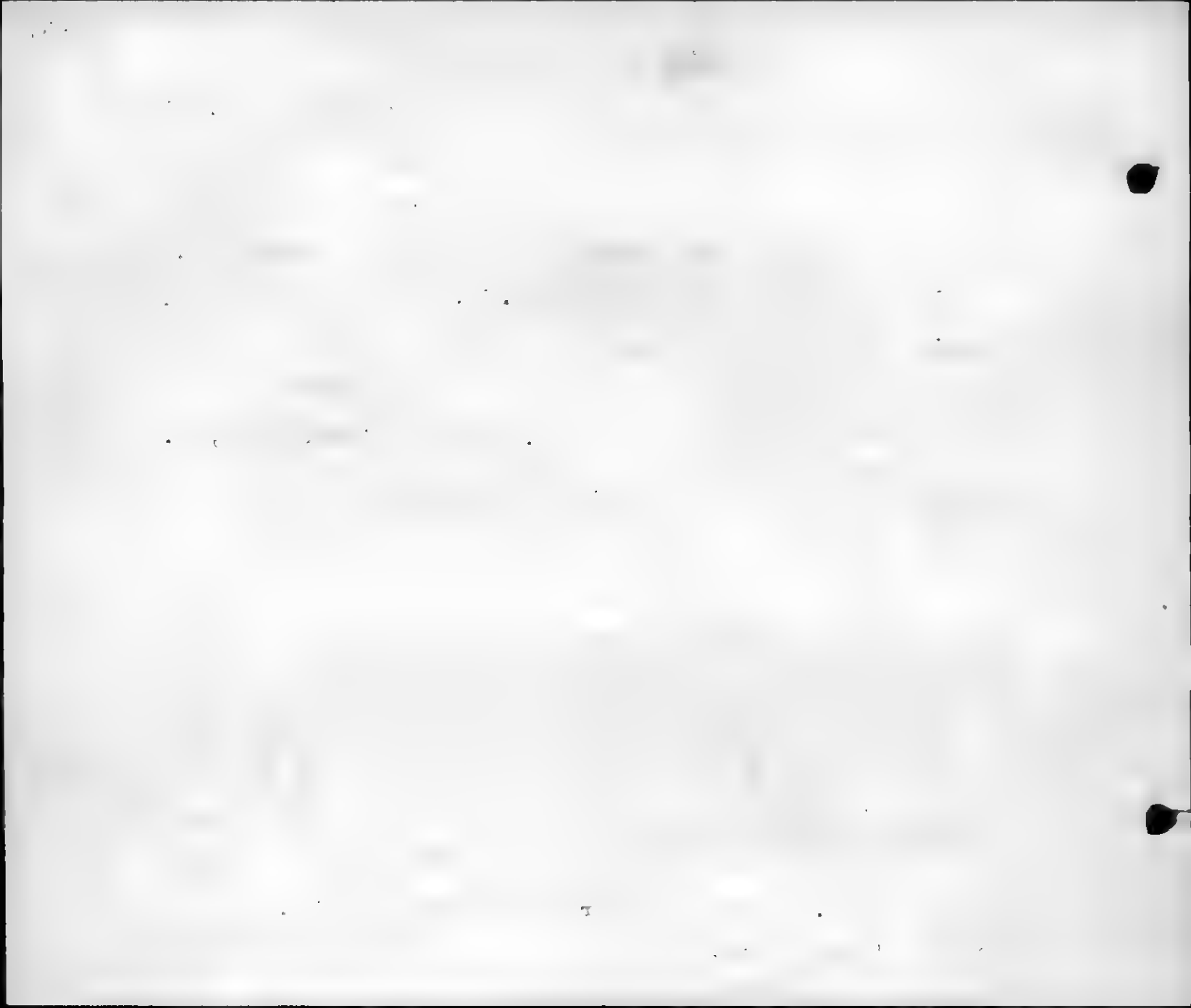
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STATE OF MARYLAND  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1589 CERTIFICATE OF DEATH

01571

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Codd Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>VIOLA STOLL BRACKEN</b>				4. DATE OF DEATH Month Day Year <b>February 22, 1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 12, 1875</b>	9. AGE (In years lost birthday) yrs. <b>85</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Augustus Stoll</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Sauter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Francis Pettijohn, Towson, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Thrombosis</b> DUE TO (c) <b>Arteriosclerosis, family</b>						INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diagnosis: Hemorrhagic stroke, lye</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>11/16/59</b> to <b>2/22/60</b> , that (I) (we) last saw the deceased alive on <b>1/16/60</b> , and that death occurred at <b>4:15</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>John Burns</b>				22b. DATE SIGNED <b>Feb 26 1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>How</b>				22d. ADDRESS <b>6604 Kew-Forest Rd. Baltimore, Md.</b>			
23a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>Feb. 24, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Walter Frey Funeral Home</b>		23d. LOCATION (City, town or county) (State) <b>Lorraine, Ohio</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>				25a. REC'D BY REG. STRAR DATE <b>FEB 26 1960</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01572

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1590

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission, a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BACK RIVER NECK</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BACK RIVER NECK</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>822 BACK RIVER NECK ROAD</u>				f. STREET ADDRESS <u>822 BACK RIVER NECK ROAD</u>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FREDERICK W BREHM</u>				4. DATE OF DEATH Month Day Year <u>FEB 12 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 3, 1876</u>	9. AGE (In years last birthday) <u>87</u> yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN HENRY BREHM</u>				14. MOTHER'S MAIDEN NAME <u>JEANETTE LAWRENCE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>MRS AMANDA BREHM 6--BACK RIVER NECK</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Aneurysm</u> <u>31X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M. B. Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M. B. DAVIS MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB 15, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEM PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. ...</u>				24a. REC'D BY REGISTRAR <u>...</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

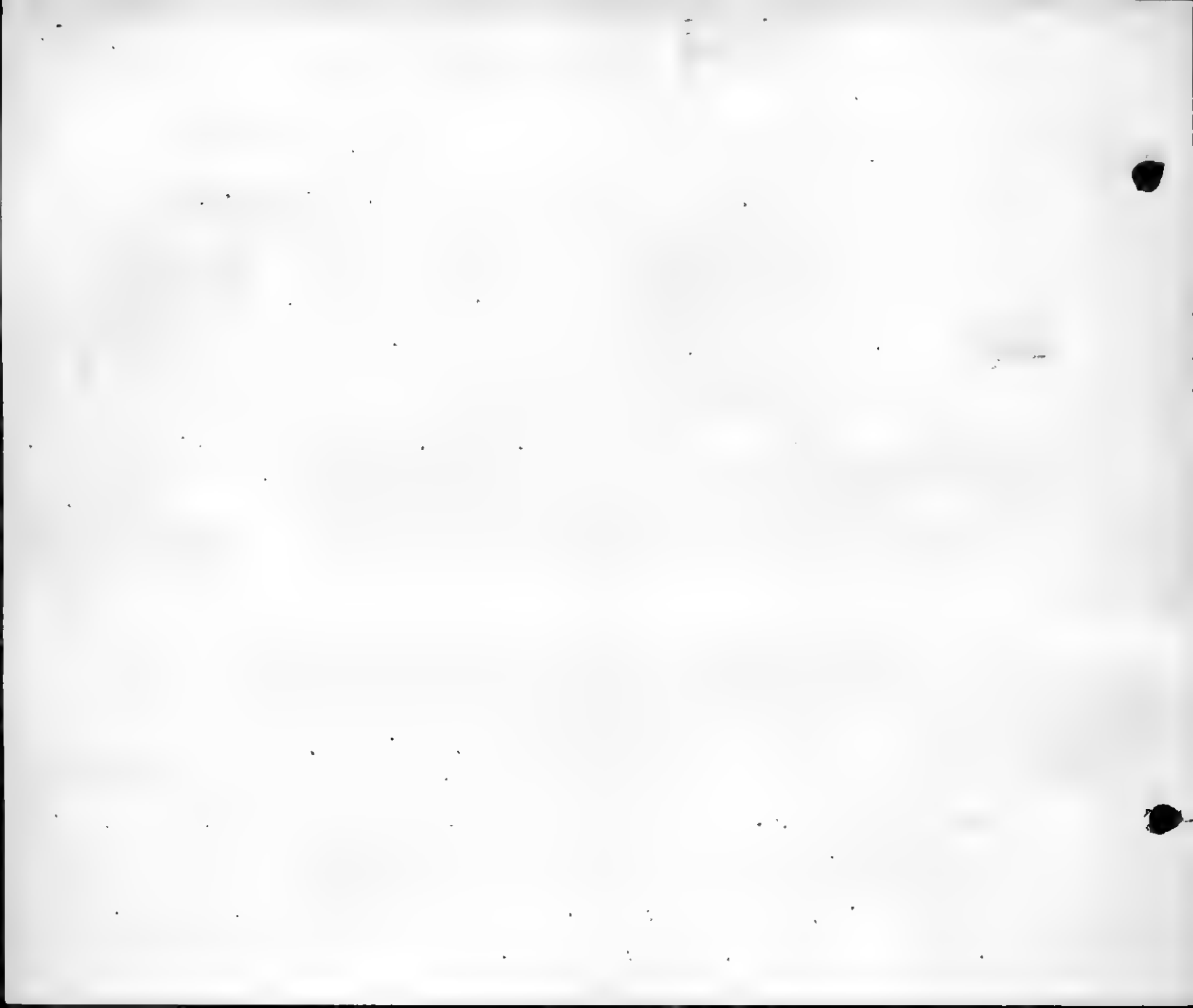


01573

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>1</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3004 Woodside Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>HENRY</b> Last <b>BRETT HOLL</b>		4. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 29, 1887</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>18</b> Hours <b>20</b> Min.	11. IF UNDER 24 HRS Months <b>12</b> Days <b>18</b> Hours <b>20</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Bretttholl</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Battenfield</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Mrs. Anna M. Bretttholl-3004 Woodside Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma, Left main bronchus, Undifferentiated, sub-carinal</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>12-18 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 22, 1957</b> to <b>Feb 3rd, 1960</b> , that I last saw the deceased alive on <b>Feb 2nd, 1960</b> , and that death occurred at <b>5:45</b> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wm Conway</b>		DATE SIGNED <b>2/4/60</b>	
PHYSICIAN'S NAME (Type) <b>Wm. Conway M.D.</b>		ADDRESS (Street, city or town, state) <b>8358 Loch Raven Blvd, Towson, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/6/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parkview Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. SANDER &amp; SONS, INC., Baltimore, Md.</b>		24. REC'D BY REGISTRAR DATE <b>FEB 5 '60</b>	
25. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

VS A15 (4)  
LSM 9/5B





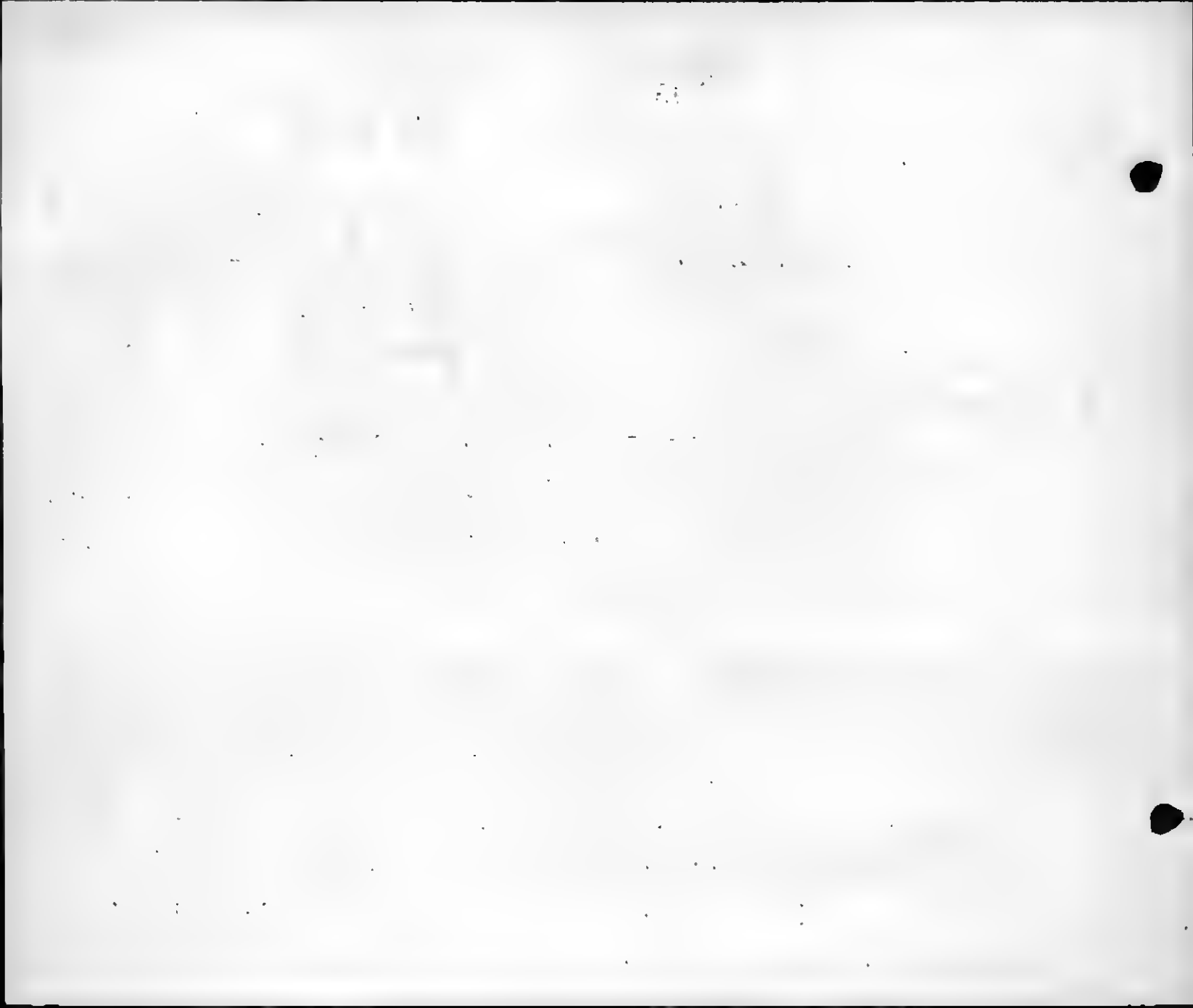
1592 CERTIFICATE OF DEATH

01574

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>530 Hampton Lane</u>		1 d. STREET ADDRESS <u>530 Hampton Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Ruth E.</u> Middle <u>Breyer</u> Last <u></u>		4. DATE OF DEATH Month <u>2-</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22, 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Wood</u>		14. MOTHER'S MAIDEN NAME <u>Emma</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u>2215-01-36750</u>	
17. INFORMANT <u>Mrs. Milton Reynolds,</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIOSCLEROSIS -</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UREMIA</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>JAN 1950</u> to <u>FEB. 25, 1960</u> , that I last saw the deceased alive on <u>2/23, 1960</u> , and that death occurred at <u>145 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph J. Cameron</u>		ADDRESS (Street, city or town, state) <u>1515 - Martin Blvd - Baltimore, Md.</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH J. CAMERON</u>		DATE SIGNED <u>2/25/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/29/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Rd</u>	
24a. REC'D BY REGISTRAR <u>MAR 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Robert L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried with the registrant prior to burial, cremation, or removal, and in any event within 72 hours after death.



# 1 FOR STATE HEALTH DEPT.

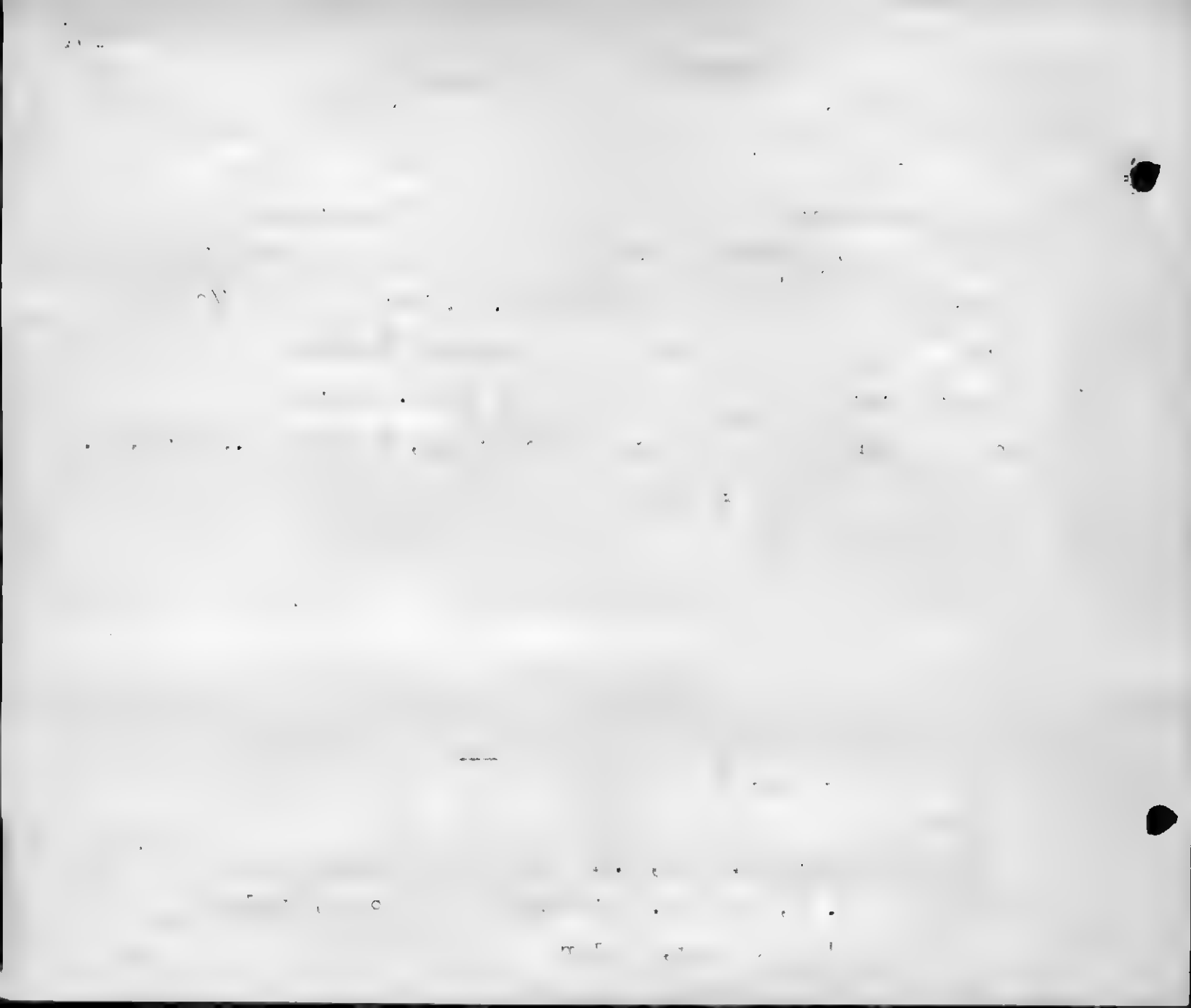
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

## Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>21 Tenbury Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Towson</b> d. STREET ADDRESS <b>1 21 Tenbury Road</b>	
3. NAME OF DECEASED (Type or print) <b>LAWRENCE PHILLIP BUCK</b>		4. DATE OF DEATH <b>February 22 19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 26, 1959</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baby</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland, Baltimore</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ronald Buck</b>		14. MOTHER'S MAIDEN NAME <b>Rose E. Freitas</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Ronald Buck, 21 Tenbury Rd., Towson, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>493X Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>DUE TO</b> (c) <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I look charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b>		M.D.	
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>		DATE SIGNED <b>2/23/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 24, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Marie Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Towson, Maryland</b>	
23. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DATE FEB 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

47285XVS



1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

01578

Reg. Dist. No. 32

1594

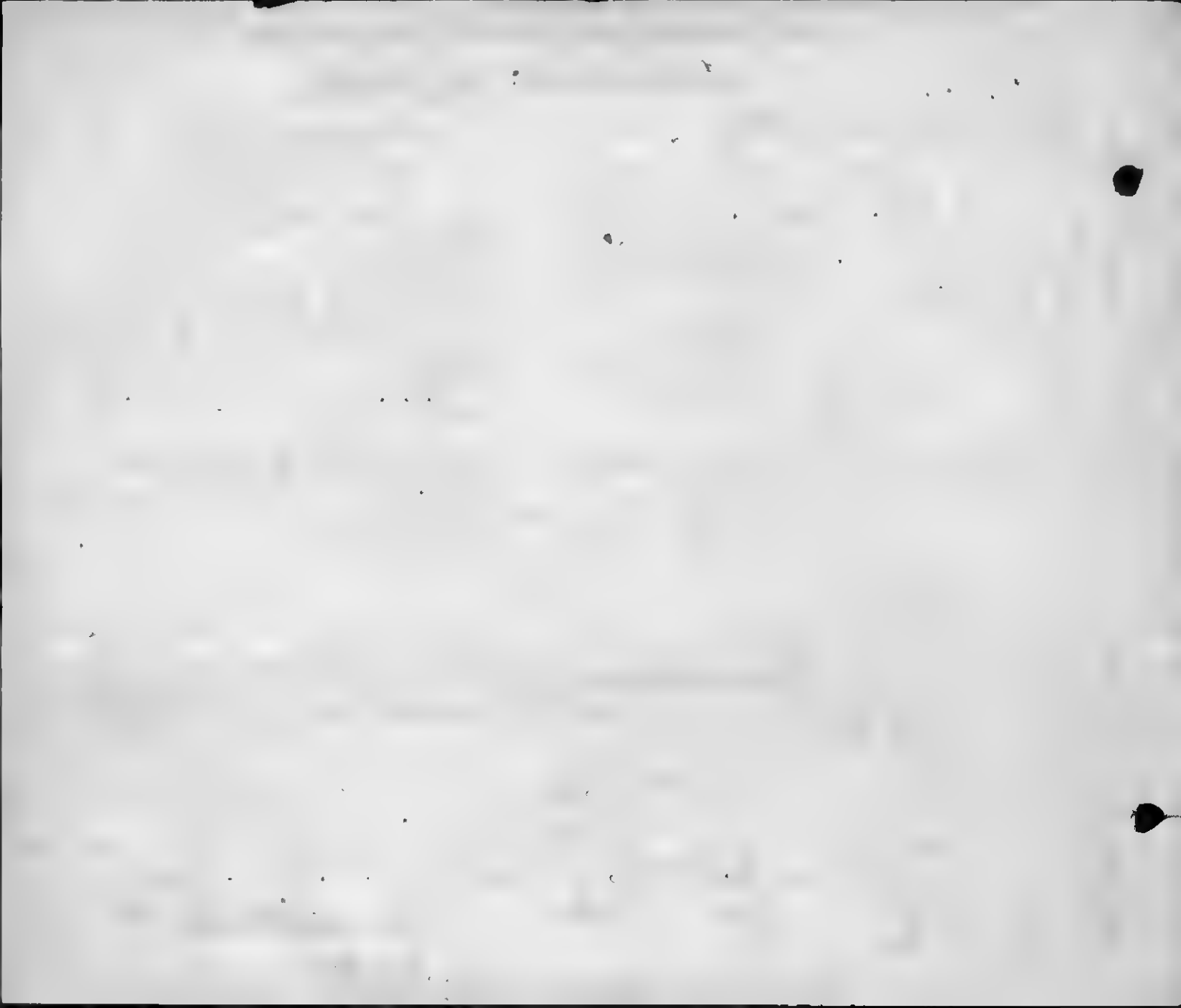
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore County</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Mt. Wilson, Md.</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mayo Post office</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) <u>Elsie</u> (Middle) <u>Lee</u> (Last) <u>Burgess</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>2</u> <u>4</u> <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2/13/1885</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>FLOYD BURGESS</u>				14. MOTHER'S MAIDEN NAME <u>SARAH LEE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Hospital Records</u> <u>Mt. Wilson State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
X IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>8/13/1959</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/13/1959</u> to <u>2/4/1960</u> , that I last saw the deceased alive on <u>2/4/1960</u> , and that death occurred at <u>11:30 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. Newcomer</u>				ADDRESS (Street, city, town, state) <u>Mt. Wilson, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/4/60</u>		NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Anne Arundel</u>	
24. REC'D BY REGISTRAR <u>FEB 17 '60</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Hopting</u>		ADDRESS <u>unmarked</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1593

CERTIFICATE OF DEATH

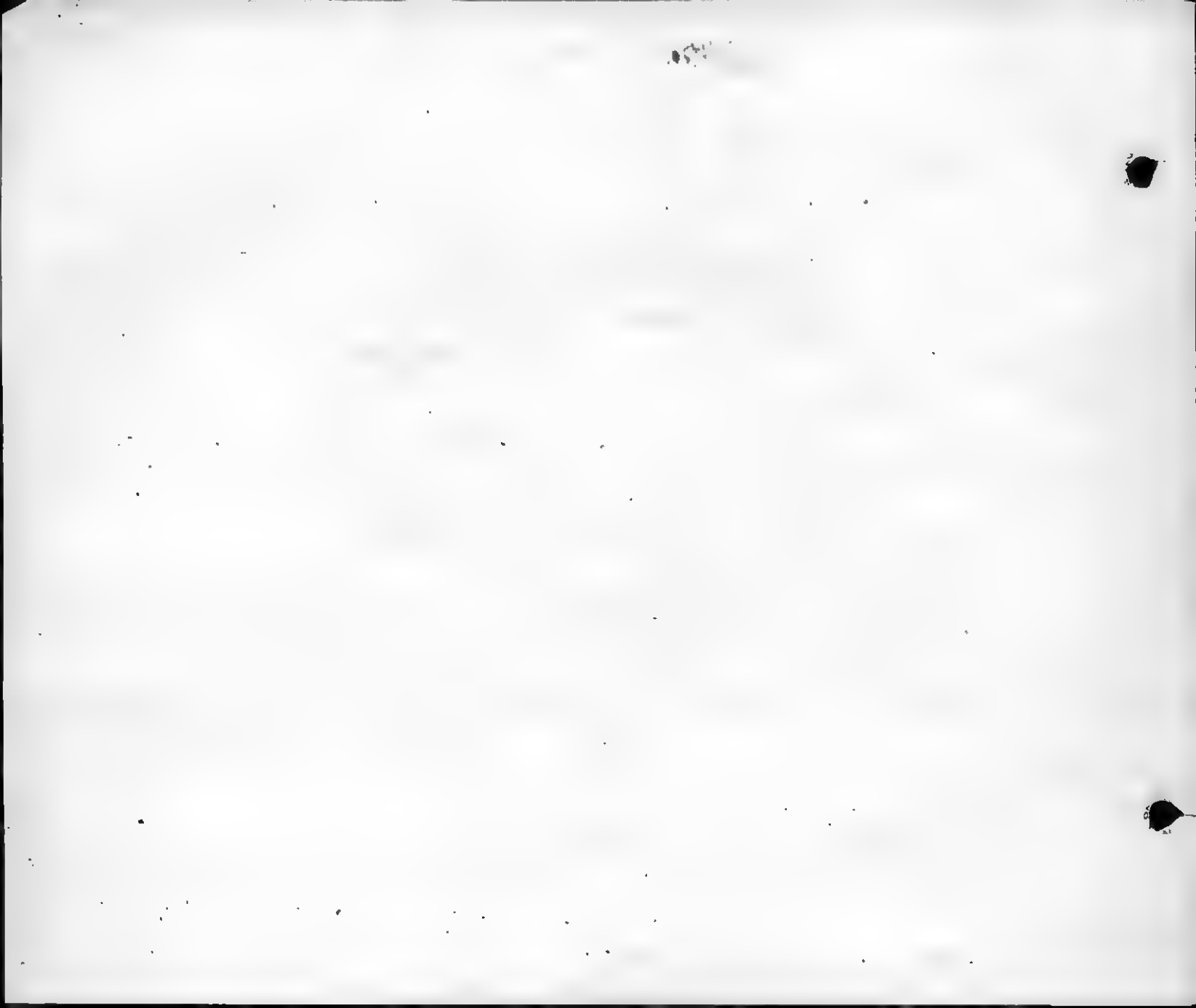
Reg. Dist. No.

01577

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2505 Linwood Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Rose</i> Middle <i>Beatrice</i> Last <i>Bush</i>		4. DATE OF DEATH Month <i>2-3-60</i> Day <i>19</i> Year <i>19</i>	
5 SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-4-1893</i>
9 AGE (In years last birthday) yrs <i>66</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Henry Doyle</i>	
14. MOTHER'S MAIDEN NAME <i>Mary O'Connor</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>719-07-9243</i>		INFORMANT <i>William Daniel Bush, Sr.</i> Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis</i> <i>157x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma Pancreas.</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Endogenous malnutrition</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4-6 wks.</i>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>fall</i> , 19 <i>58</i> , to <i>2-3</i> , 19 <i>60</i> , that I lost saw the deceased alive on <i>12-29</i> , 19 <i>60</i> , and that death occurred at <i>12:10</i> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John C. Hyle</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>7527 Glen Rd. Balt 6</i> <i>2-4-60</i>	
PHYSICIAN'S NAME (Type) <i>JOHN C. Hyle</i>			
22a. BURIAL REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>2/6/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 9 '60</i>	
ADDRESS <i>5305 Harford Rd</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1596 CERTIFICATE OF DEATH

01578

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in lines</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>VICTOR</u> Middle <u>CAPHAN</u> Last <u>CAPHAN</u>		4 DATE OF DEATH Month <u>2</u> - Day <u>18</u> - Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>70</u> yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Barry</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barry</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Reubin</u>		14. MOTHER'S MAIDEN NAME <u>Not known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>Jacob Caphan - 2905 Taney Rd</u>	
17. INFORMANT <u>Jacob Caphan</u>		Address <u>2905 Taney Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphocarcinoma</u> <u>200.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Oct 1960</u> to <u>Feb 1960</u> , that I last saw the deceased alive on <u>Feb 1960</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Daniel J. Schwartz</u>		ADDRESS (Street, city or town, state) <u>2320 Eutaw Pl</u>	
PHYSICIAN'S NAME (Type) <u>Daniel J. Schwartz, M. D.</u>		DATE SIGNED <u>1/15/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2-19-60</u>	<u>Rosedale</u>	<u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob K... 2100 Eutaw Pl</u>		24a. REG'D BY REGISTRAR DATE <u>FEB 23 '60</u>	24b. REGISTRAR'S SIGNATURE <u>C. King S. K...</u>

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



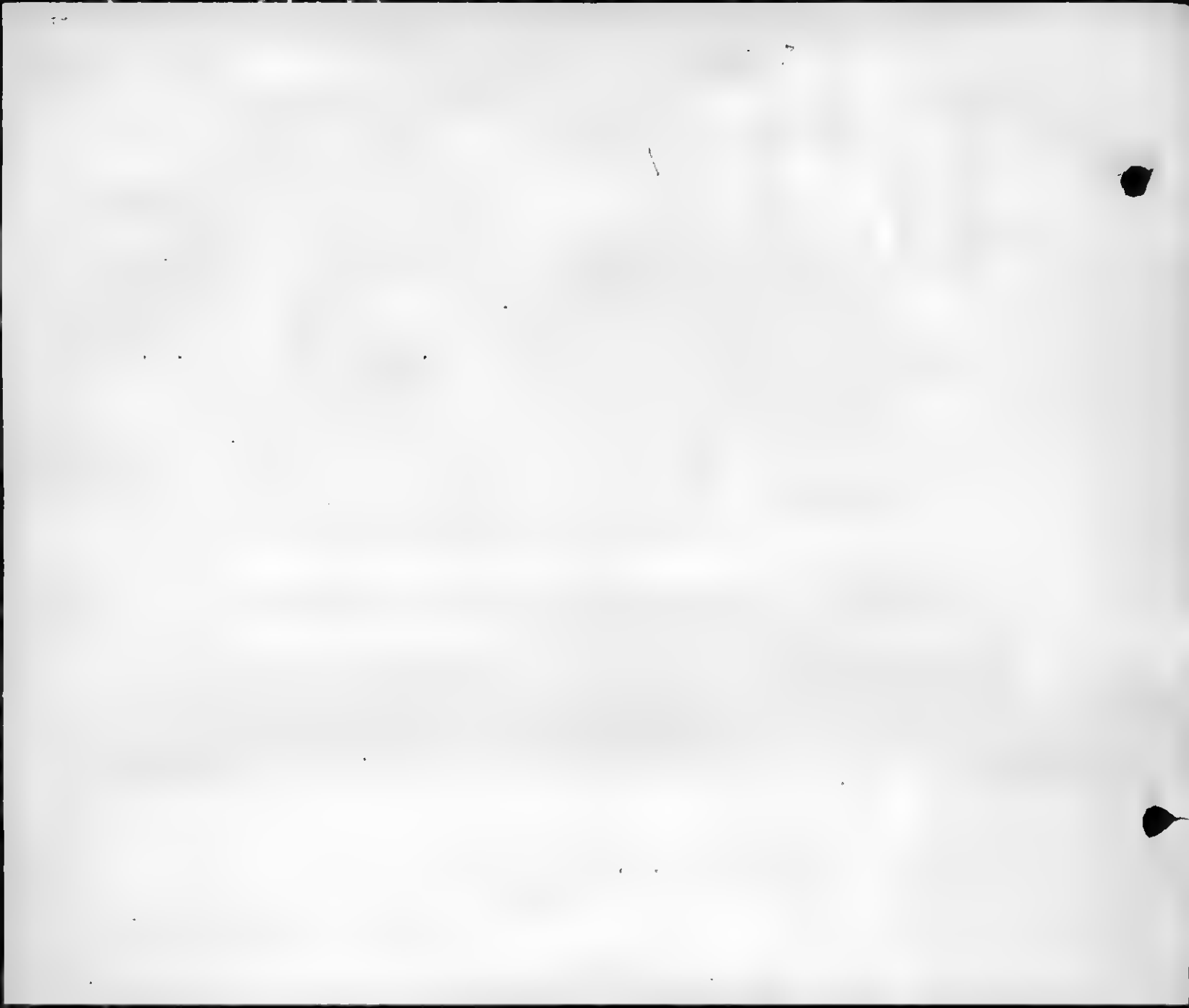
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1597 CERTIFICATE OF DEATH

Reg. Dist. No. 01579

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1yr 7mth 28dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>620 Murdock Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Etta</b> Middle <b>Agnes</b> Last <b>Carpenter</b>		4. DATE OF DEATH Month <b>February</b> Day <b>28</b> Year <b>19 60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 20, 1881</b>
9. AGE (In years last birthday) <b>79</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Patrick Moran</b>		14. MOTHER'S MAIDEN NAME <b>Jane ? Mayberry</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records; SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal bronchopneumonia</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Infarctive myocardial fibrosis</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 30, 19 58</b> to <b>Feb. 28, 19 60</b> , that I last saw the deceased alive on <b>Feb. 28, 19 60</b> , and that death occurred at <b>2:30 a. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachsker</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 2-29-60</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachsker, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/3/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>VILLIMANTIC CEMETERY</b>	22d. LOCATION (City town, or county) (State) <b>VILLIMANTIC CONN.</b>
23. BURIAL DIRECTOR'S SIGNATURE <b>H. Sander &amp; Sons, Inc. Balto. Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 2 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

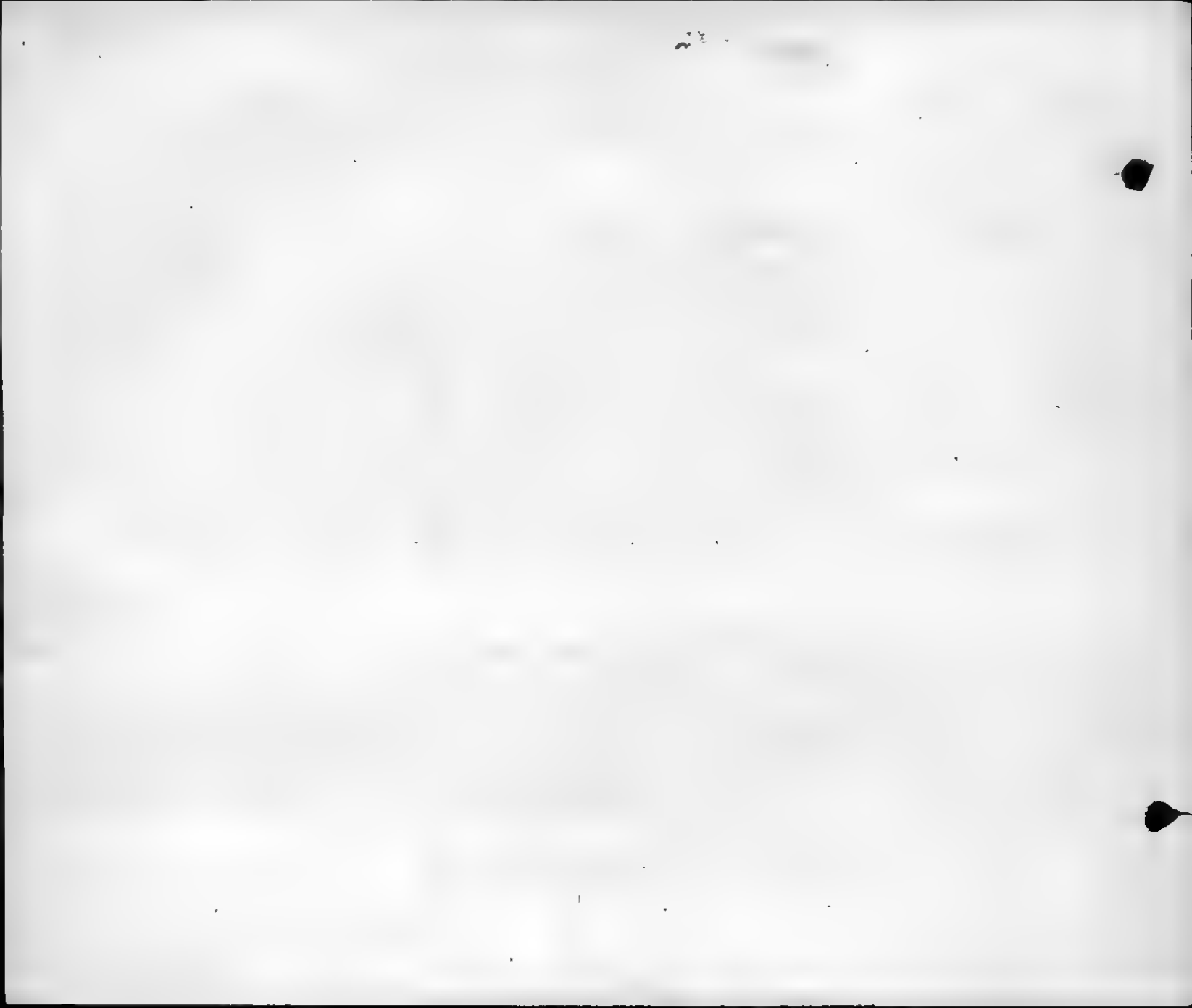
1598

## CERTIFICATE OF DEATH

01580

Item 2 Film 250 2-14-60 68

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Pr. Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Budget Rest Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Eva Cashell</i>		4. DATE OF DEATH <i>Feb. 6 1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/20/89</i>
9. AGE (In years past birthday) <i>70</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nurse</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Pract.</i>	
11. BIRTHPLACE (State or foreign country) <i>W. Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Hospital records Spring Grove</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>		<i>48 hrs.</i>	
422.1 DUE TO		<i>Chr. Arteriosclerotic Cardio-Vascular Disease</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) <i>10 da.</i>	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>7-30-1958</i> to <i>2-6-</i> 1960 that (I) (we) last saw the deceased alive on <i>2-6-</i> 1960, and that death occurred at <i>4 PM</i> , from the causes and on the date stated above			
22a. SIGNATURE <i>Wilmer K. Gallagher</i>		22b. DATE SIGNED <i>2-6-60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Wilmer K. Gallagher, M.D.</i>		22d. ADDRESS <i>6209 Frederick Ave., Baltimore 28, Md.</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>2-12-60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. John's</i>	23d. LOCATION (City, town, or county) (State) <i>Olney, Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Francis H. Barber</i>		ADDRESS <i>Laytonville, Md.</i>	
25a. REC'D BY REGISTRAR DATE <i>FEB 12 '60</i>		25b. REGISTRAR'S SIGNATURE	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

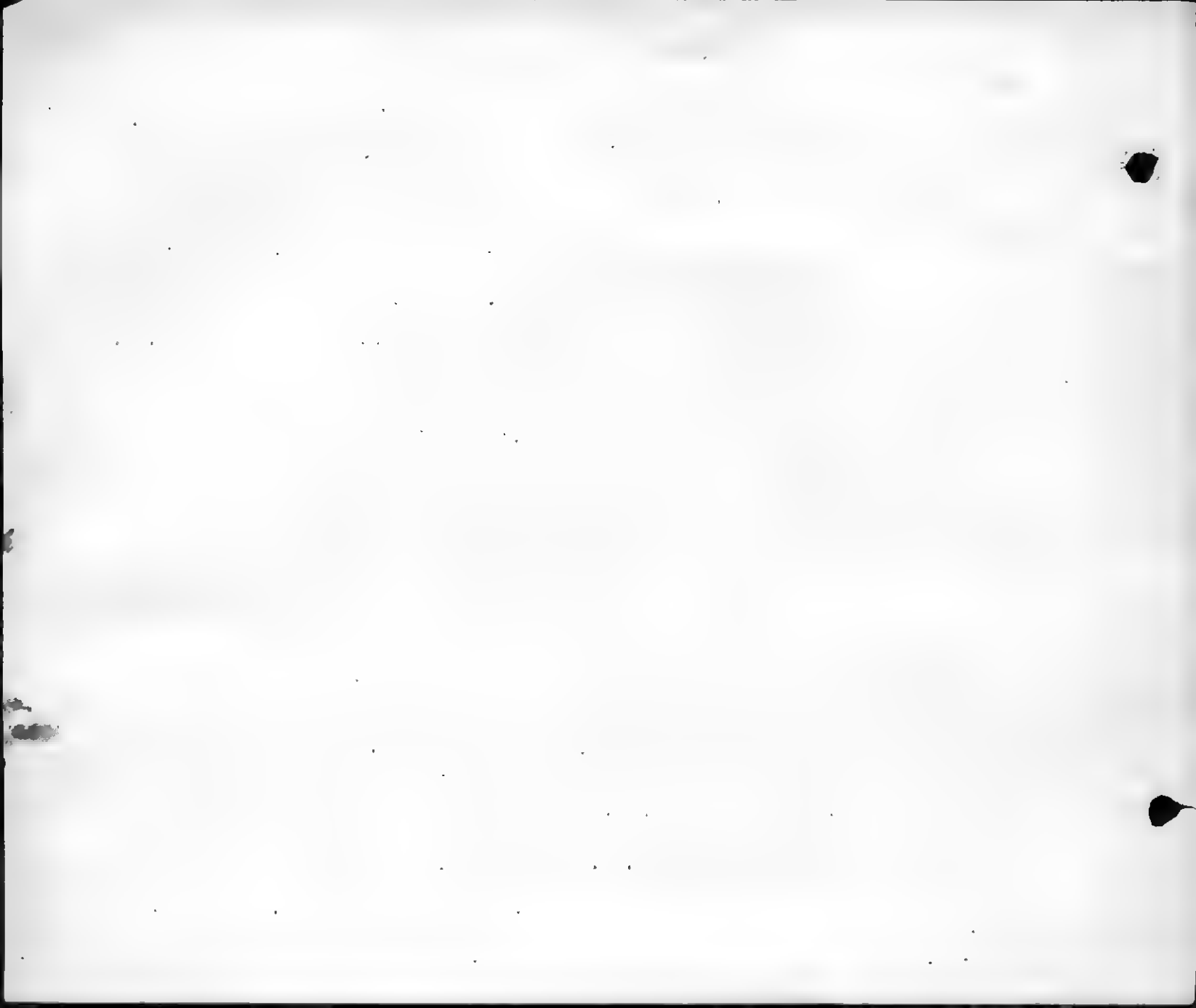
## 1593 CERTIFICATE OF DEATH

Reg. Dist. No.

01581

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonville</b>		c. LENGTH OF STAY IN 1b <b>1yr10mth12dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Melford Goldie Castle</b>		4. DATE OF DEATH Month Day Year <b>February 26 1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 1, 1886</b>
9. AGE (In years lost birthday) <b>74 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk own</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>None</b>	
INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422.1</b> IMMEDIATE CAUSE (a) <b>Cardiac failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic cardiovascular disease</b> (c) <b>Generalized arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept. 22, 1959</b> to <b>Feb. 26, 1960</b> , that I last saw the deceased alive on <b>Feb. 26, 1960</b> , and that death occurred at <b>1:00a</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachler</b> M.D.		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>2-26-60</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachler, M. D.</b>		<b>Catonville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 29, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Temple Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Russell Co., Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Horne</b> ADDRESS <b>4001 Ritchie Hwy.</b>		24a. REC'D BY REGISTRAR <b>MAR 1 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1

1600

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01582

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN lb <b>30 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore(25)</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore(25)</b> d. STREET ADDRESS <b>1107 Edwight Court</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>F.</b> Last <b>CHANEY</b>		4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 22, 1894</b>
9. AGE (In years last birthday) <b>65</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Glass Cutter</b>	11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Samuel L. Chaney</b>	
14. MOTHER'S MAIDEN NAME <b>Helen E. Jones</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	
16. SOCIAL SECURITY NO. <b>212-10-8271</b>		17. INFORMANT <b>Clinical Records, VAH, Balto. 18, Md. FT. HOWARD DIV.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, STAPHYLOCOCCIC, RIGHT</b> <b>RECENT</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PULMONARY CONGESTION AND EDEMA, BILATERAL</b> <b>RECENT</b> (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>UNKNOWN</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Surgical absence partial stomach, old. Gastro jejunostomy, old.</b> <b>Chronic adhesive peritonitis. Arteriosclerotic nephrosclerosis. Benign P. H.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>RECENT</b> <b>UNKNOWN</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>Jan. 9</b> 19 <b>60</b> to <b>Feb. 8</b> 19 <b>60</b> , that (we) last saw the deceased alive on <b>Feb. 8</b> 19 <b>60</b> , and that death occurred at <b>2:40 AM</b> from the causes and on the date stated above			
22a. SIGNATURE <b>W. J. Pijanowski</b>		22b. DATE <b>2/8/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. J. PIJANOWSKI, M.D.</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-11-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James L. McCully</b>		25a. REC'D BY REGISTRAR <b>FEB 10 '60</b>	
ADDRESS <b>237 Patapsco, Baltimore, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

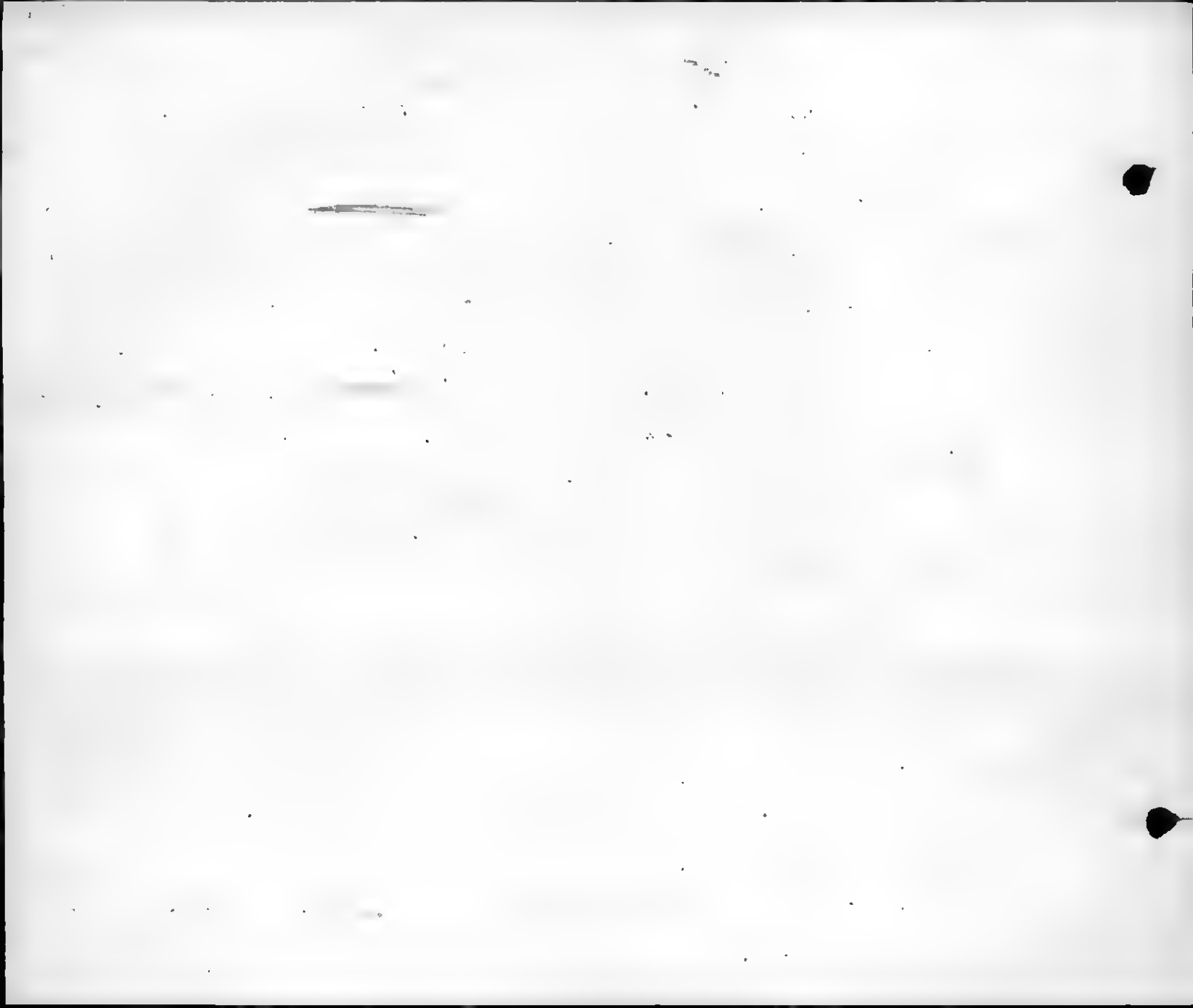
## 1601 CERTIFICATE OF DEATH

Reg. Dist. No.

01583

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>SINCE FEB. 2, 60</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BENJAMIN</b> Middle <b>F.</b> Last <b>CHARNOCK</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>14</b> Year <b>19 60</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-23-1867</b>
9. AGE (In years last birthday) <b>92</b> yrs.		10. IF UNDER 1 YEAR Months <b>92</b> Days <b>92</b> Hours <b>92</b> Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BLACKSMITH</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOSEPH CHARNOCK</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH WILLIAMS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>HOSPITAL RECORD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY ARTERY DISEASE</b> DUE TO <b>GENERAL ARTERIOSCLEROSIS</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GENERAL ARTERIOSCLEROSIS</b> (c) <b>GENERAL ARTERIOSCLEROSIS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>FEB. 2, 19 60</b> , to <b>FEB. 14, 19 60</b> , that I last saw the deceased alive on <b>FEB. 14, 19 60</b> , and that death occurred at <b>9:15 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>P. K. Yip.</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>	
PHYSICIAN'S NAME (Type) <b>P. K. Yip, M.D.</b>		DATE SIGNED	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-17-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Old Fields</b>		22d. LOCATION (City, town, or county) (State) <b>Hughesville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 18 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		24c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01584

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Balti</u> <span style="float: right;">1603</span> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balti 7, Md. 1 mo.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7020 Stinson Mill Rd</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balti</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balti 7, Md.</u> d. STREET ADDRESS <u>7020 Stinson Mill Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>ROBT. SCOTT CHELTON</u> First Middle Last <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Jan 20 1960</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>7</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>30</u> Days <u>30</u> <b>IF UNDER 24 HRS.</b> Hours <u>30</u> Min. <u>30</u>		<b>4. DATE OF DEATH</b> Month <u>Feb</u> Day <u>19</u> Year <u>1960</u> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Infant</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Infant</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Balti, Md.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>			
<b>13. FATHER'S NAME</b> <u>James Chelton</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Betty Lucile Jones</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>None</u> <b>16. SOCIAL SECURITY NO.</b> <u>None</u> <b>17. INFORMANT</b> <u>Betty L. Chelton</u> Address <u>7020 Stinson Mill Rd</u> <u>None</u> <u>None</u> <u>None</u> <u>Balti 7, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>None - Pneumonia - Bronchitis</u> <u>501X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) <u>St Enteritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: <u>None</u> <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part I of Item 18.) <u>None</u>		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>None</u> 19 p. m. <u>None</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>None</u> <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input "="" checkbox="" checked="" type="checkbox/&gt;, Accident &lt;input type="/>, Suicide <input checkbox="" type="checkbox/&gt;, Homicide &lt;input type="/>, Undetermined cause <input 2"="" style="vertical-align: top;" type="checkbox/&gt;.&lt;/b&gt; &lt;/td&gt; &lt;/tr&gt; &lt;tr&gt; &lt;td colspan="/> <b>ACTUAL SIGNATURE</b> <u>D. D. Caples</u> <b>EXAMINER'S NAME (Type)</b> <u>D. D. CAPLES</u> </b>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <u>Feb 19, 1960</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u> <b>22b. DATE THEREOF</b> <u>2-22-60</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Peters Cemetery</u> <b>22d. LOCATION (City, town, or county)</b> (State) <u>Baltimore</u>		<b>24a. REC'D BY REGISTRAR</b> <u>FEB 25 1960</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Frank</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>William Cook, Inc., 1217 St. Paul Street</u> <b>ADDRESS</b>		<b>DATE</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1602

CERTIFICATE OF DEATH

01585

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i>		c. LENGTH OF STAY IN 1b <i>Catonville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Caton Ridge Conv. Home</i>		d. STREET ADDRESS <i>1112 Glenwood Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Carrye Christle</i>		4. DATE OF DEATH Month <i>Feb</i> Day <i>3</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/13/77</i>
9. AGE (In years last birthday) <i>82</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wm. Munch</i>		14. MOTHER'S MAIDEN NAME <i>Ackwind</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Helen Harrington</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis grossly</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>7-6</i> 1957 to <i>7-2</i> 1960 that (I) (we) last saw the deceased alive on <i>7-1</i> 1960, and that death occurred at <i>10:45</i> M, from the causes and on the date stated above			
22a. SIGNATURE <i>Cliff Ratliff, Jr.</i> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>CLIFF RATLIFF, JR.</i>		22d. ADDRESS <i>4605 Edmondson Ave</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
<i>Burial</i>		<i>2/5/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Western</i>		23d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Mike [unclear] &amp; Son</i>		ADDRESS <i>28</i>	
25a. REC'D BY REGISTRAR DATE <i>FEB 8 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thoms</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

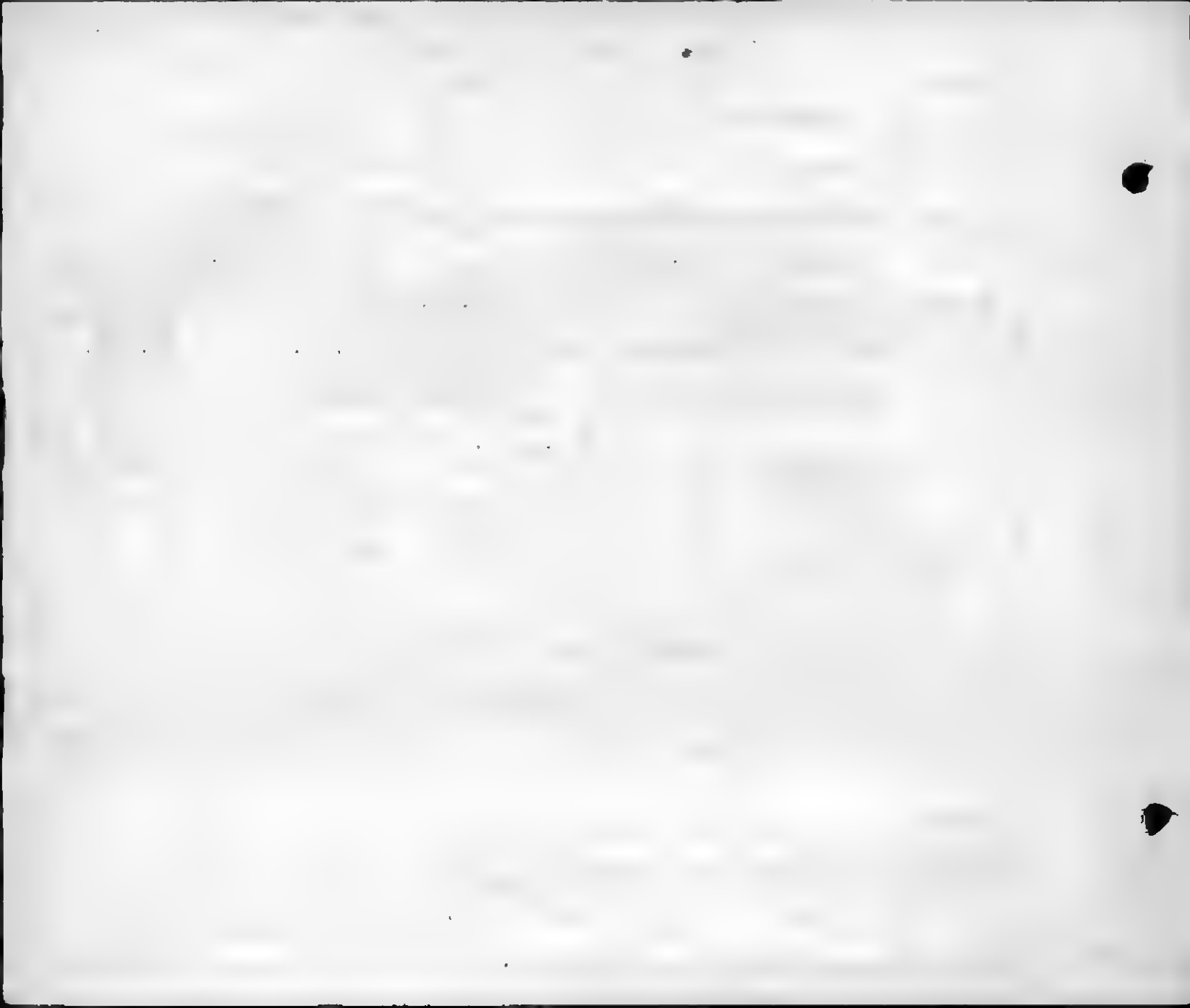
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1604 CERTIFICATE OF DEATH

Reg. Dist. No.

01586

1. PLACE OF DEATH a. COUNTY <b>Towson</b> <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>1</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>110 Murdock Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>G.</b> Last <b>Cincotta</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>17</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 13, 1912</b>	9. AGE (In years last birthday) <b>48</b> yrs.	IF UNDER 1 YEAR Months <b>48</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Sparrows Point</b>		11. BIRTHPLACE (State or foreign country) <b>New York, N. Y.</b>	
13. FATHER'S NAME <b>Salvatore Cincotta</b>				14. MOTHER'S MAIDEN NAME <b>Marie DeAngelo</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-09-0954</b>		17. INFORMANT <b>Mrs. Sadie Brocato</b>		Address <b>403 Register Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>199.2</b> DUE TO <b>Senescent degeneration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>None known, primary interdependence</b> (c) <b>1</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Sept 1, 1917</b> to <b>Feb 17, 1960</b> , that I last saw the deceased alive on <b>Feb 17, 1960</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore, Maryland</b> DATE SIGNED <b>2/19/60</b>							
ACTUAL SIGNATURE <b>Matthew C. Neale</b> M.D.				PHYSICIAN'S NAME (Type) <b>MATTHEW C. NEALE</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/22/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Farace, Inc.</b>				ADDRESS <b>712-14 E. North Ave.</b>		24a. REC'D BY REGISTRAR <b>FEB 19 60</b>	
				24b. REGISTRAR'S SIGNATURE <b>William S. Thum</b>			



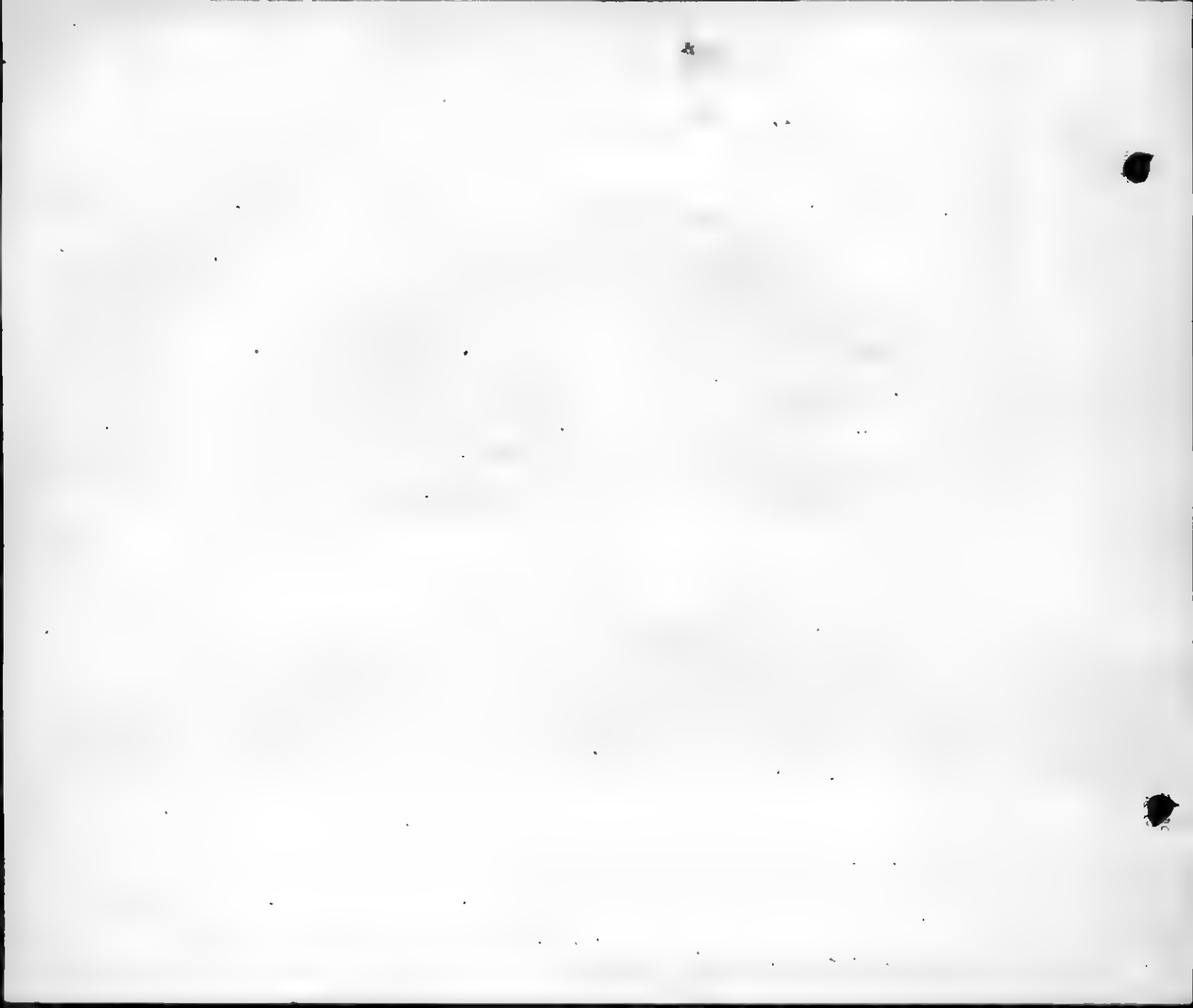
1605 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Armcast Nursing Home</i>		d. STREET ADDRESS <i>920 Belgian Ave.</i>	
3. NAME OF DECEASED (Type or print) First <i>Jean</i> Middle <i>C.</i> Last <i>Clark</i>		4. DATE OF DEATH Month <i>Feb.</i> Day <i>18</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 26, 1893</i>
9. AGE (In years last birthday) <i>66</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Orlando Price</i>	
14. MOTHER'S MAIDEN NAME <i>Mary Berry</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs. Berry Rogers</i> Address <i>Box 153 Record Rd</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>414X</i> DUE TO <i>Phenomatic cardiovascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebrovascular accident</i> 2-14-60			INTERVAL BETWEEN ONSET AND DEATH <i>?</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Feb 14</i> , 1960, to <i>Feb 18</i> , 1960, that I last saw the deceased alive on <i>Feb 18</i> , 1960, and that death occurred at <i>M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Fredrick J. Vollmer</i> M.D.		ADDRESS (Street, city or town, state) <i>6100 York Rd Balto-12</i> DATE SIGNED <i>2-22-60</i>	
PHYSICIAN'S NAME (Type) <i>FREDERICK J. VOLLMER M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Feb 23, 1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lousahn Funeral Home</i> ADDRESS <i>7401 Belair Rd</i>		24a. REC'D BY REGISTRAR <i>Feb 24 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

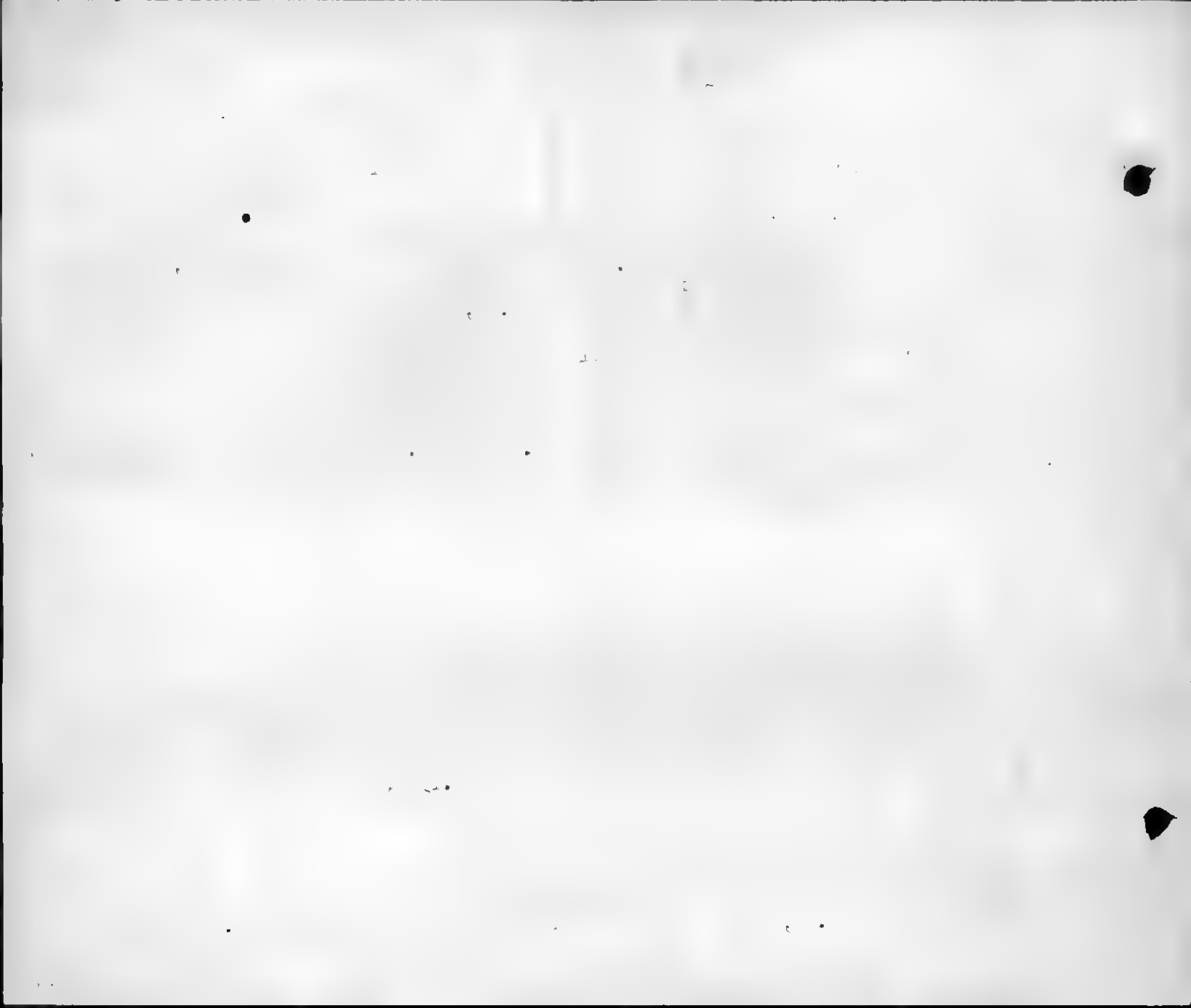
## 1606 CERTIFICATE OF DEATH

01588

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Parkville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8019 Ridgely Oak Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>H.</b> Last <b>Cline</b>		4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 4, 1880</b>
9. AGE (In years last birthday) <b>79</b> yrs		10. IF UNDER 1 YEAR Months Days Hours M n	11. IF UNDER 24 HRS Months Days Hours M n
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Weaver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cotton Mill</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John Cline</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Cox</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Esther M. Wells</b>		Address <b>8019 Ridgely Oak Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arterio-sclerosis</b> DUE TO (c) <b>4 days</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1-29, 1960</b> , to <b>2-2, 1960</b> , that I last saw the deceased alive on <b>1-30, 1960</b> , and that death occurred at <b>9:15 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Lee K Fargo</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>8155 LOCH RAVEN BLVD 2-3-60</b>	
PHYSICIAN'S NAME (Type) <b>DR LEE K FARGO</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 5, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Burgee Funeral Home</b>		ADDRESS <b>3631 Falls Road</b>	
24a. REC'D BY REGISTRAR <b>FEB 5 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01589

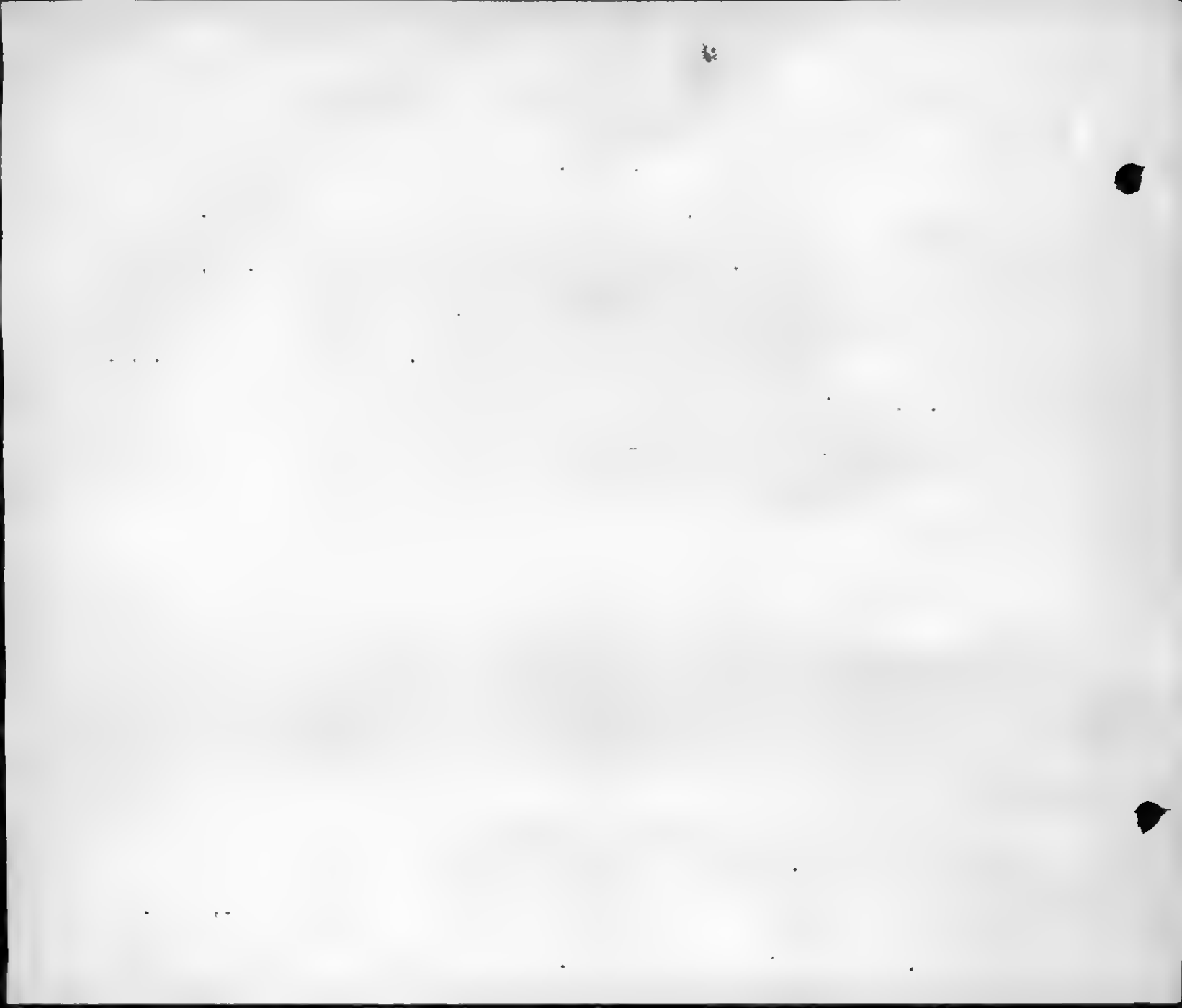
Reg. Dist. No.

1607

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. LENGTH OF STAY IN 1b <b>10 Yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>444 Edgewater Apts.</b>		e. STREET ADDRESS <b>444 Edgewater Apts.</b>	
3. NAME OF DECEASED (Type or print) <b>James B. Collins</b>		4. DATE OF DEATH <b>Feb. 7, 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>May 11, 1871</b>
9. AGE (In years last birthday) <b>88 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
13. FATHER'S NAME <b>R. H. Collins</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>415-32-6892</b>	
17. INFORMANT <b>Laura Collins</b>		Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arterio Scler. of Heart Ar.</b> (c) <b>10 yrs</b> DUE TO stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>16 yrs</b>			INTERVAL BETWEEN ONSET AND DEATH <b>16 yrs</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Jack C. Collins</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Jack C. Collins</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>2-7-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>2/8/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Irish Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Claiborne Co., Tenn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James E. Brudzinski</b>		ADDRESS <b>1407 Eastern Ave.</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 9 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Pages 1, 2, and 3 should be used as a burial-transit permit. Fill pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

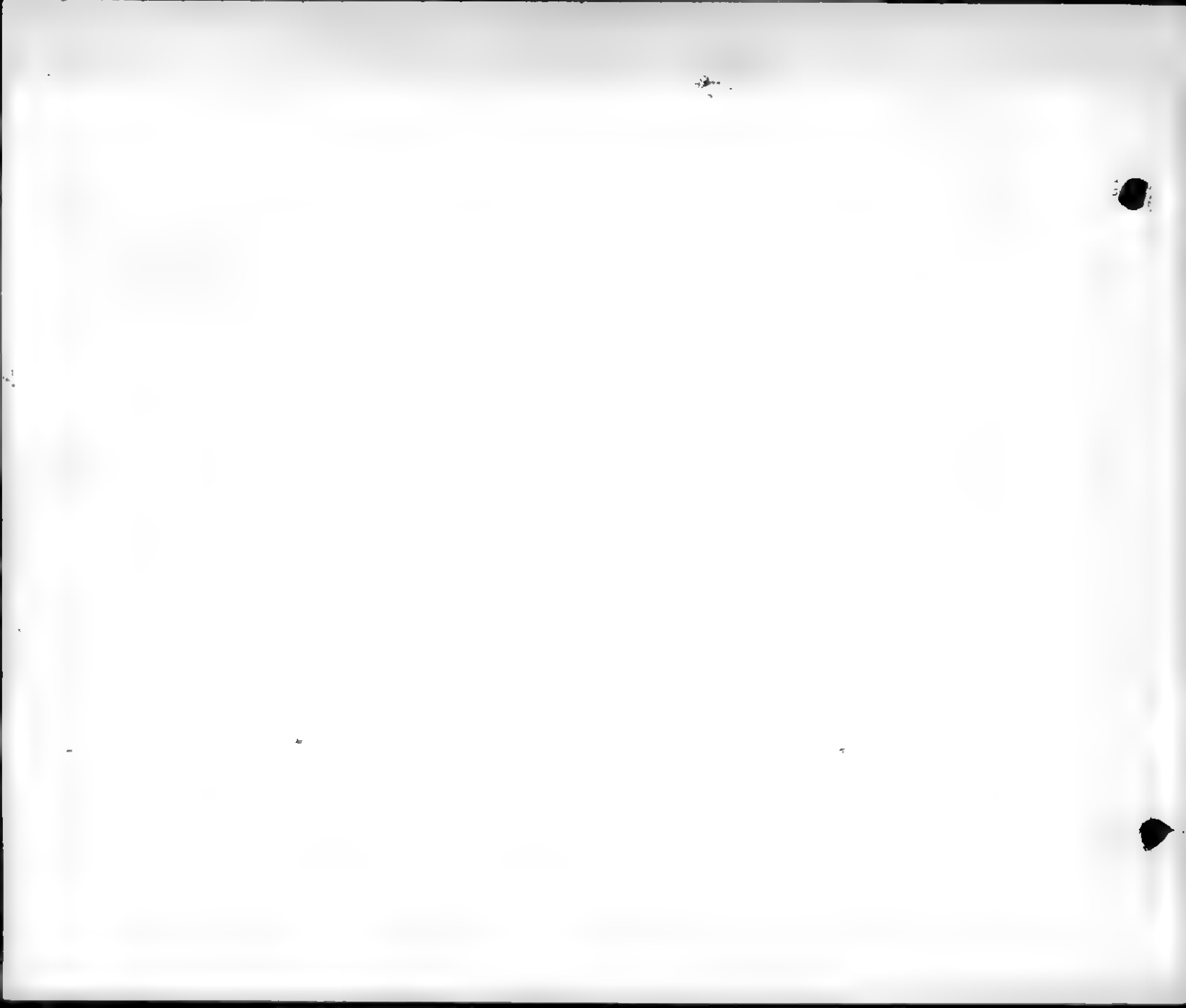
01590

1608

1. NAME OF DECEASED (Type or Print) <b>Miss Mary M. Connor</b>		2. DATE OF DEATH <b>2/20/1960</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>Mercy Villa</b> ADDRESS OR LOCATION <b>6400 Bellona Avenue</b>		4. USUAL RESIDENCE (Where deceased lived If institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____ C. CITY OR TOWN <b>Baltimore</b> (If outside city limits write RURAL and give township) <b>2V314</b> D. STREET ADDRESS <b>1524 Lakeside Ave.</b> (If rural, give location)	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>2/2/1882</b>
9. AGE (in years last birthday) <b>78</b>		If Under 1 Year: Months <b>0</b> Days <b>18</b> If Under 24 Hours: Hours _____ Min. _____	
10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Int. Revenue, U.S. Gov't.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Texas, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Texas, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Texas, Maryland</b>	
13. FATHER'S NAME <b>Michael F. Connor</b>		14. MOTHER'S MAIDEN NAME <b>Mary Fitzgerald</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Miss Isabel deC Connor - 1524 Lakeside Ave.</b>		ADDRESS	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death)  ANTECEDENT CAUSES <b>46</b>  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST	CAUSE OF DEATH (A) <b>Coronary Heart Failure</b> DUE TO _____ (B) <b>Arteriosclerotic Heart Disease</b> DUE TO _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>  <b>4 years</b>
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Exhaustion</b>		<b>10 years</b>
	19. DATE OF OPERATION <b>February 1960</b>	19a. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Exhaustion</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
	22. I certify that (I) (this hospital) attended the deceased from <b>November 1956</b> to <b>February 1960</b> that (I) (we) last saw the deceased alive on <b>February 20</b> 1960 and that in (my) (our) opinion death occurred at <b>9:45 A.M.</b> from the causes and on the date stated above.		
23a. SIGNATURE <b>Edmund Paul Coffey, M.D.</b>		23b. ADDRESS <b>2843 St. Paul St.</b>	23c. DATE SIGNED <b>2/22/60</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>2/23/60</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's, Texas, Md.</b>	24d. LOCATION (City, town, or county) (State) <b>Texas, Maryland</b>
25a. DATE REC'D BY HEALTH DEPT <b>FEB 23 1960</b>		25b. NAME OF REGISTRAR <b>H. H. Mease</b>	25c. FUNERAL DIRECTOR <b>H. H. Mease &amp; Son - 805 N. Calvert St. 12</b>

THIS IS A PERMANENT RECORD.  
 NO INFORMATION SHOULD BE CAREFULLY SUPPLIED.  
 WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.



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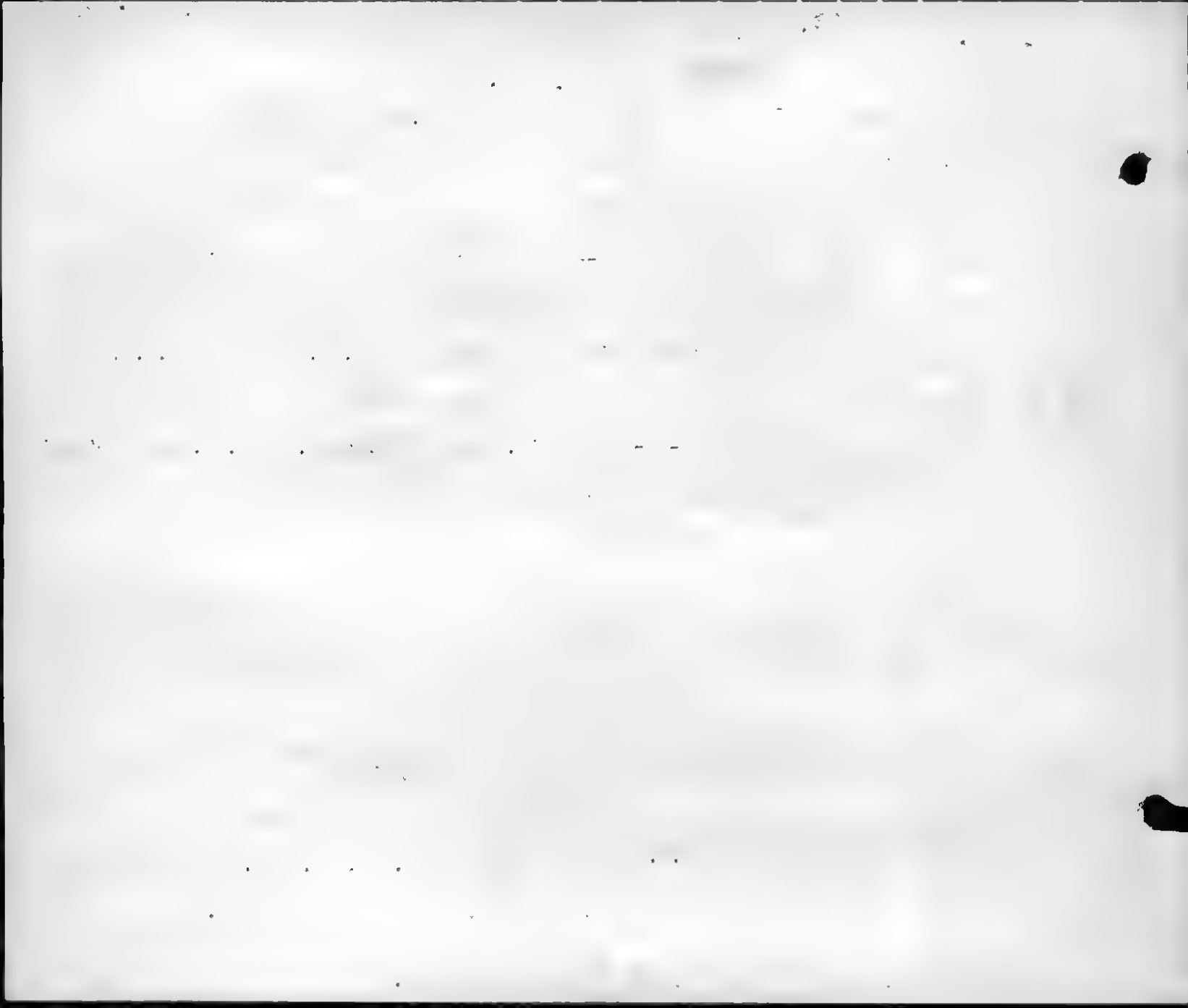
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## 1669

01591

ARLINGTON S. PHILLIPS, 1808 N. MONROE ST., BALTO., MD.



## 1610 CERTIFICATE OF DEATH

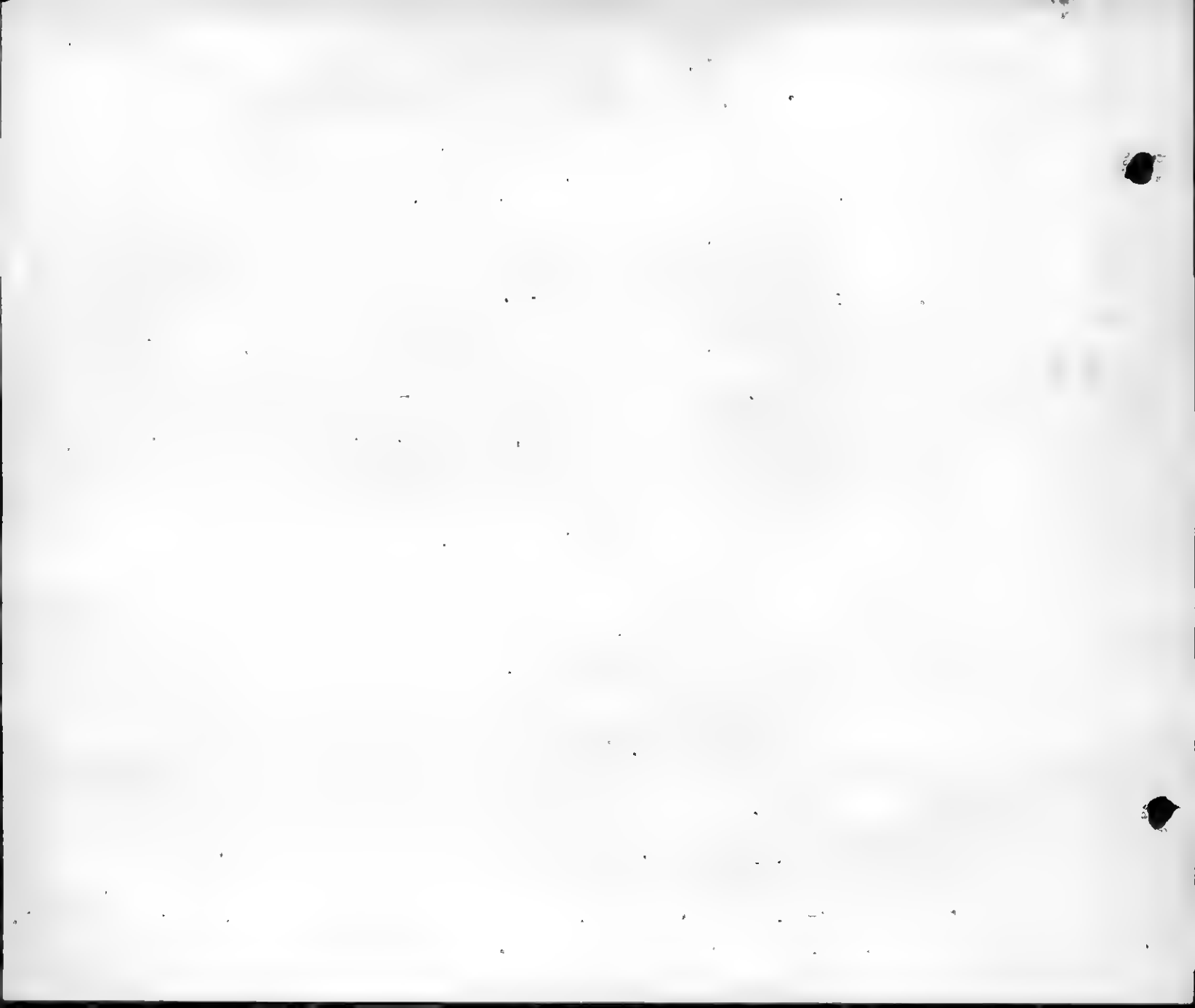
01592

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore Co.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3V01, 4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>168 Dumbarton Road</b>		d. STREET ADDRESS <b>1614 Wilkens Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>KATHERINE</b> Middle <b>CORCORAN</b> Last		4. DATE OF DEATH Month <b>Feb.</b> Day <b>19</b> Year <b>19 60</b>	
5. SEX <b>Fem.</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-18-1875</b>
9. AGE (In years last birthday) yrs. <b>83</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>County Galway, Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Patrick Burke</b>		14. MOTHER'S MAIDEN NAME <b>--</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b> Address <b>Mr. Bourke Corcoran, 1608 Wilkens Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2</b> <b>Acute cardiac dilatation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Chronic myocarditis</b> DUE TO (c) <b>Renovascular disease &amp; hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>senility</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. _____ p. m. _____ 19__		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Jan 1</b> , 19 <b>60</b> , to <b>Feb 18</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Feb 16</b> , 19 <b>60</b> , and that death occurred at <b>12 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>A. C. Calao</b> M.D. <b>H. J. Fallon</b> PHYSICIAN'S NAME (Type) <b>A. E. Calao</b> <b>17411. Ind</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-22-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem</b>		22d. LOCATION (City, town, or county) (State) <b>4300 Old Frederick Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>THOMAS J. KENNY, INC</b>		24a. REC'D BY REGISTRAR <b>FEB 23 '60</b>	
ADDRESS <b>1600 HOLLINS ST.</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Krasner</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

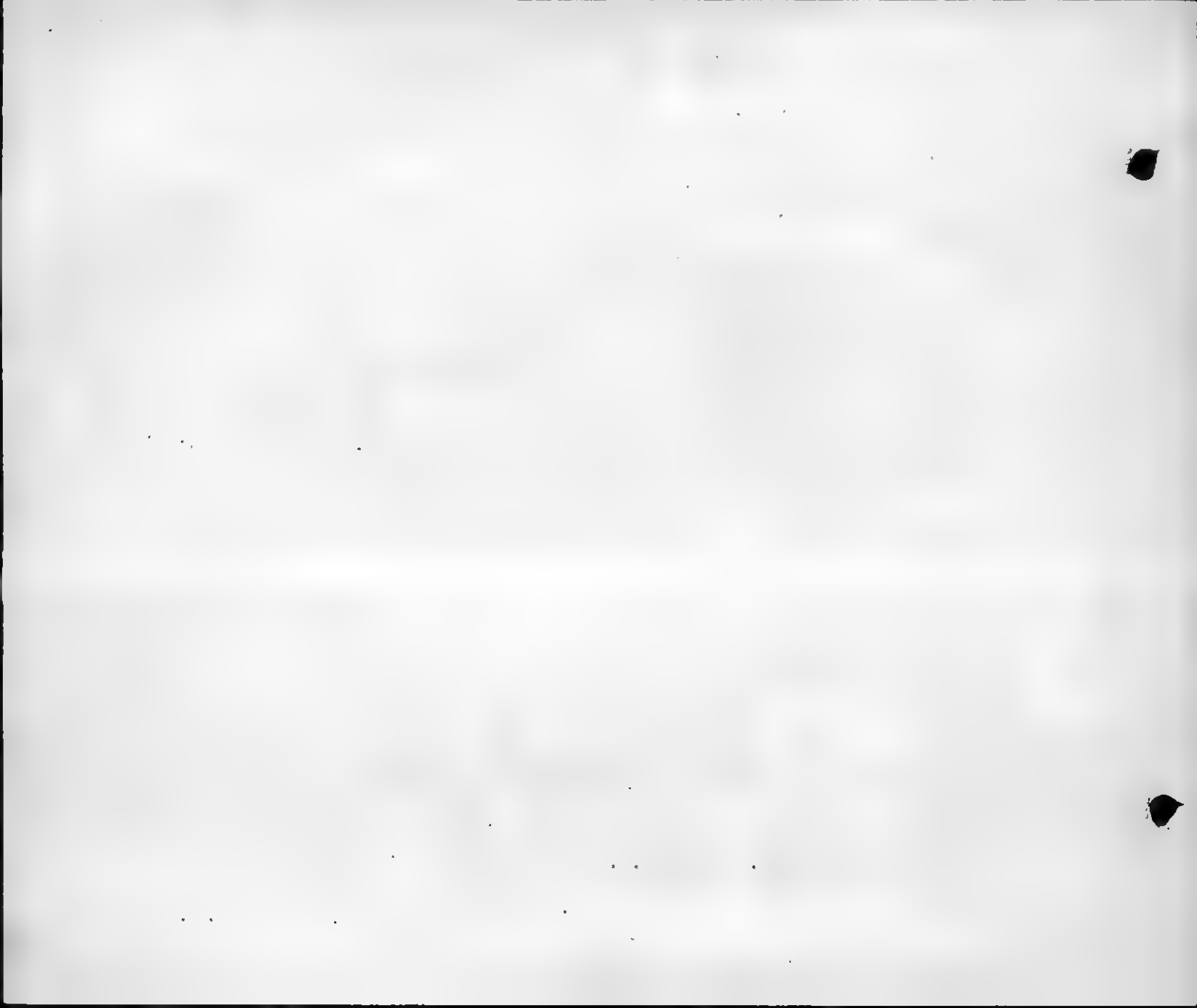
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

## MEDICAL CERTIFICATION

VS A15 (4)  
15M 10/57





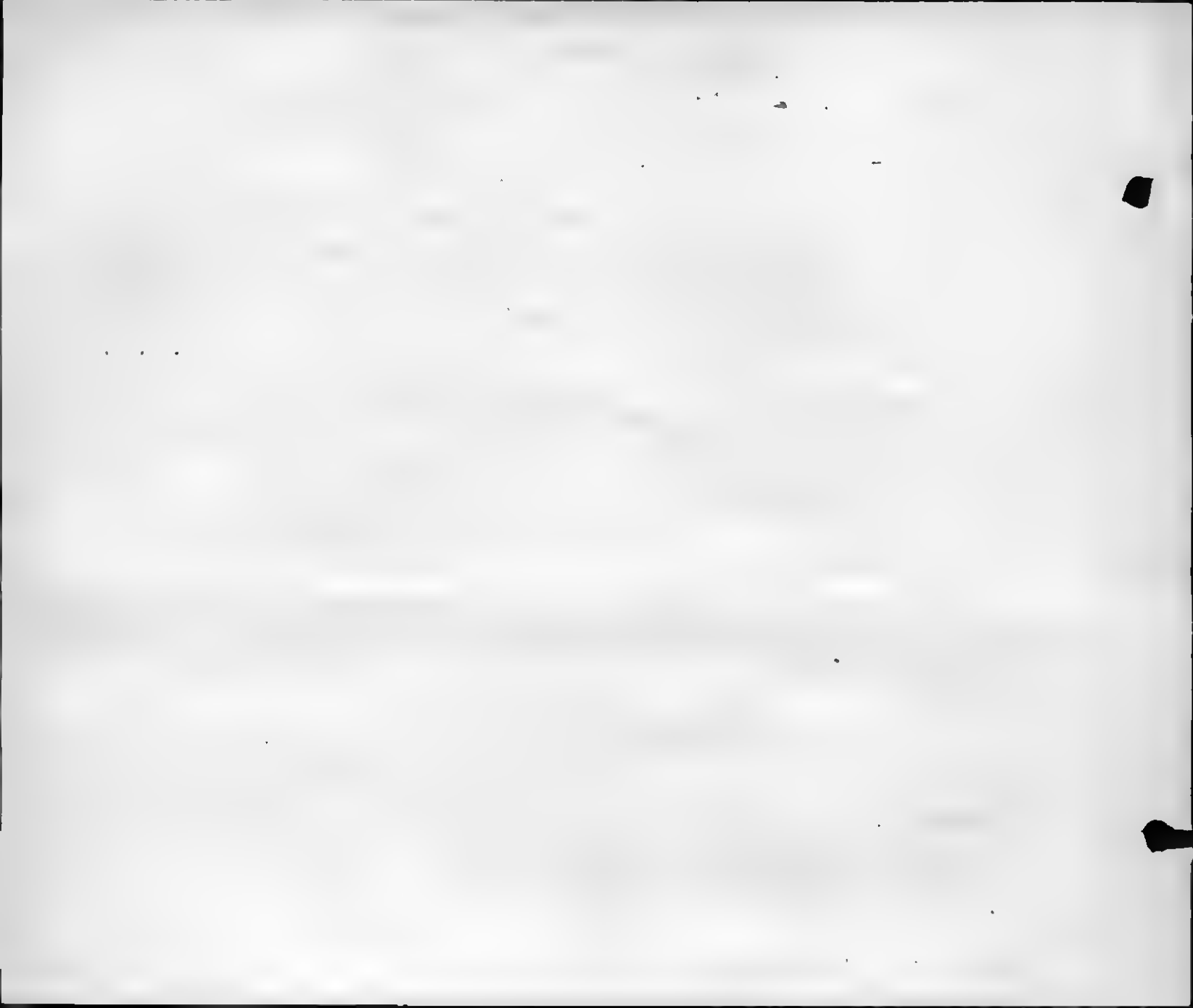
## 1612 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson-</b>		c. LENGTH OF STAY IN 1b <b>5 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stella Maris Hospice</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
f. STREET ADDRESS <b>4003 Edmondson Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Pamela</b> Last <b>Cummins</b>		4. DATE OF DEATH Month <b>2</b> Day <b>28</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/1/1876</b>
9. AGE (In years last birthday) <b>84 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>James Logue</b>		14. MOTHER'S MAIDEN NAME <b>Harriett Lucas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>25034</b>	
17. INFORMANT <b>Mrs G. Lady Wilson</b>		Address <b>2021 Winford</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>442X</b> DUE TO <b>hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <b>hypertension</b> DUE TO <b>hypertension</b> (c) <b>hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2-4 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 1960</b> to <b>Feb 28, 1960</b> , that I last saw the deceased alive on <b>Feb 28, 1960</b> , and that death occurred at <b>12:15 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>2/28/60</b>			
ACTUAL SIGNATURE <b>Glenn F. Seitz</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Glenn F. Seitz</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3-2-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Glenn F. Seitz</b>		ADDRESS <b>5209 York Rd</b>	
24a. REC'D BY REGISTRAR <b>MAR 2 60</b>		24b. REGISTRAR'S SIGNATURE <b>Glenn F. Seitz</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01595

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>21yr19dys</u>		d. STREET ADDRESS <u>154 North Curley Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle Last <u>D'Adamo</u>		4. DATE OF DEATH Month <u>February</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 11, 1915</u>
9. AGE (in years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frank P. D'Adamo</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Rose Long</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tracheal obstruction</u>  <u>921.7</u> DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.            (b) <u>Epileptic seizure while eating food</u>            DUE TO            (c)         </p> </div> <div style="width: 35%; text-align: center;"> <p>INTERVA. BETWEEN ONSET AND DEATH</p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pt. apparently sustained seizure while eating evening meal and apparently aspirated food into the trachea</u>	
20c. TIME OF INJURY Month, Day, Year <u>6:15</u> <u>2-11</u> <u>1960</u> Hour <u>6:15</u> P. M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>	
20f. (City or town) <u>Catonville</u>		(County) (State) <u>28, Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo. M. Kieffer</u>		DATE SIGNED <u>2-12-60</u>	
EXAMINER'S NAME (Type) <u>George M. Kieffer, M. D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/16/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>BLABROWSKI 2818 E. BALTIMORE ST.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>John S. Hand</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

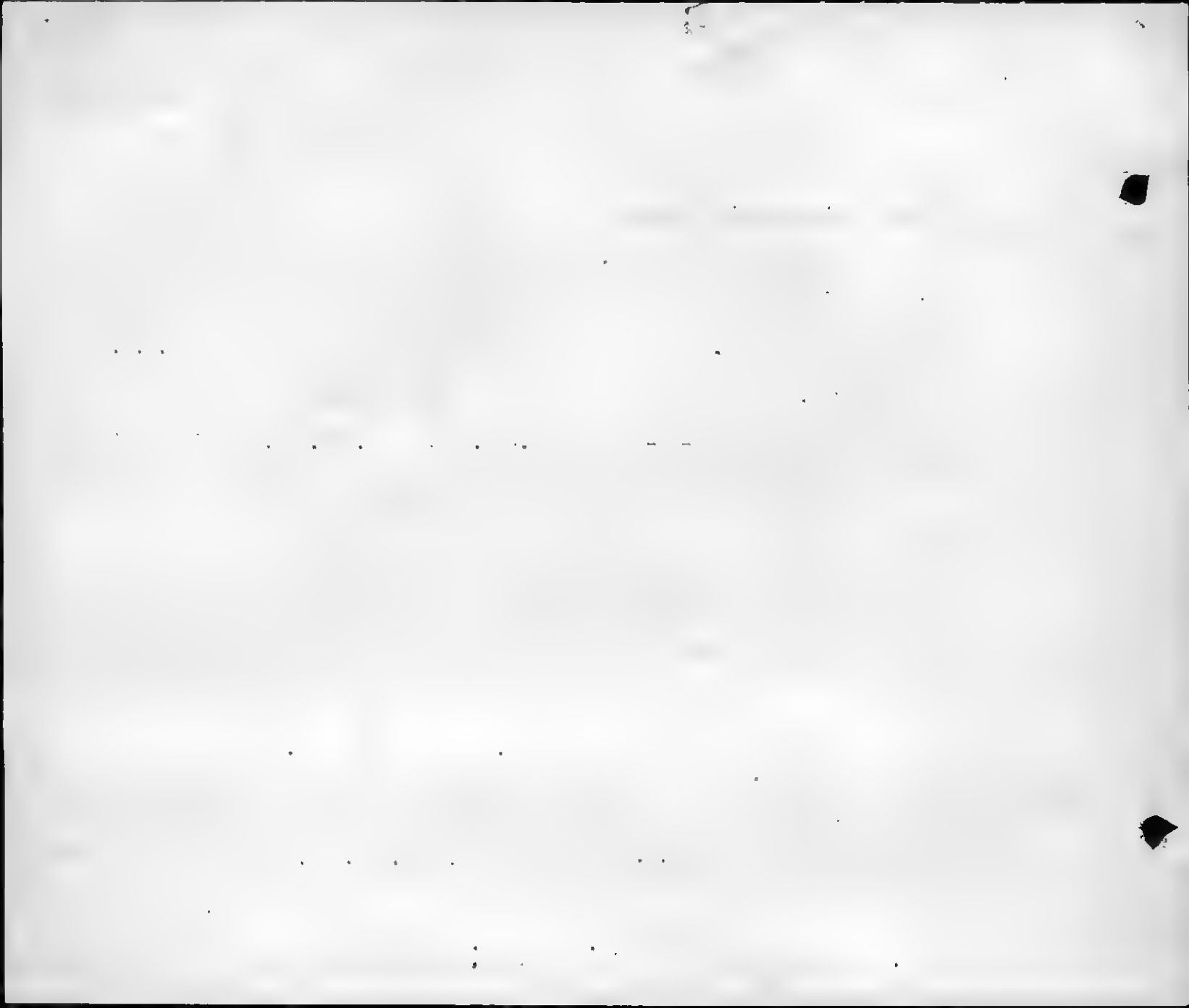


**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**1614 CERTIFICATE OF DEATH**

01596

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			c. LENGTH OF STAY IN 1b <b>71 Days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1625 Beason Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>WILLIAM P. DALEY</b>				<b>4. DATE OF DEATH</b> Month <b>FEBRUARY</b> Day <b>27</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/29/84</b>	
9. AGE (in years last birthday) <b>75</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grain Inspector</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O Railway</b>		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>	
13. FATHER'S NAME <b>William J. Daley</b>				14. MOTHER'S MAIDEN NAME <b>Mary Daley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW I</b>		16. SOCIAL SECURITY NO. <b>217-20-1705</b>		17. INFORMANT <b>Clin. Rec. VAH, Balto. Md. Ft. Howard Division</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <b>BRONCHOGENIC CARCINOMA</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>METASTASIS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 YEARS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 18</b> 19 <b>60</b> , to <b>Feb. 27</b> 19 <b>60</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Feb. 27</b> 19 <b>60</b> , and that death occurred at <b>6:25 PM</b> from the causes and on the date stated above							
22a. SIGNATURE <i>Charles Allen, M.D.</i> M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES ALLEN, M.D.</b>				22d. ADDRESS <b>VAH, BALTO. MD. FT. HOWARD DIVISION 2/27/60</b>			
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/2/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. Stevens</b> <i>Funeral Home</i>				ADDRESS <b>1501 E. Fort Ave. Baltimore 30, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 3 '60</b>	
				25b. REGISTRAR'S SIGNATURE <i>Charles L. Stevens</i>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL QUALIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

01597

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 4</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Convalescent Home 301 W. Chesapeake Ave.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b>			
f. STREET ADDRESS <b>421 Regester Avenue,</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John H. Davis Sr.</b>				4. DATE OF DEATH Month <b>February</b> Day <b>21</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 11, 1883</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(Ret'd) Bay Captain</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John H. Davis</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Price</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>J. Gordon Davis</b> Address <b>421 Regester Avenue</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Accompanying Cardiac Vascular Disease</b> <b>443 x</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Nov 10</b> , 19 <b>59</b> , to <b>Feb 21</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Feb 21</b> , 19 <b>60</b> , and that death occurred at <b>9:38 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6805 York Rd Baltimore 12 Md</b> DATE SIGNED <b>2/23/60</b>							
ACTUAL SIGNATURE <b>Laurence C. Post</b> M.D.							
PHYSICIAN'S NAME (Type) <b>LAURENCE C. Post</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-24-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc</b> ADDRESS <b>1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	





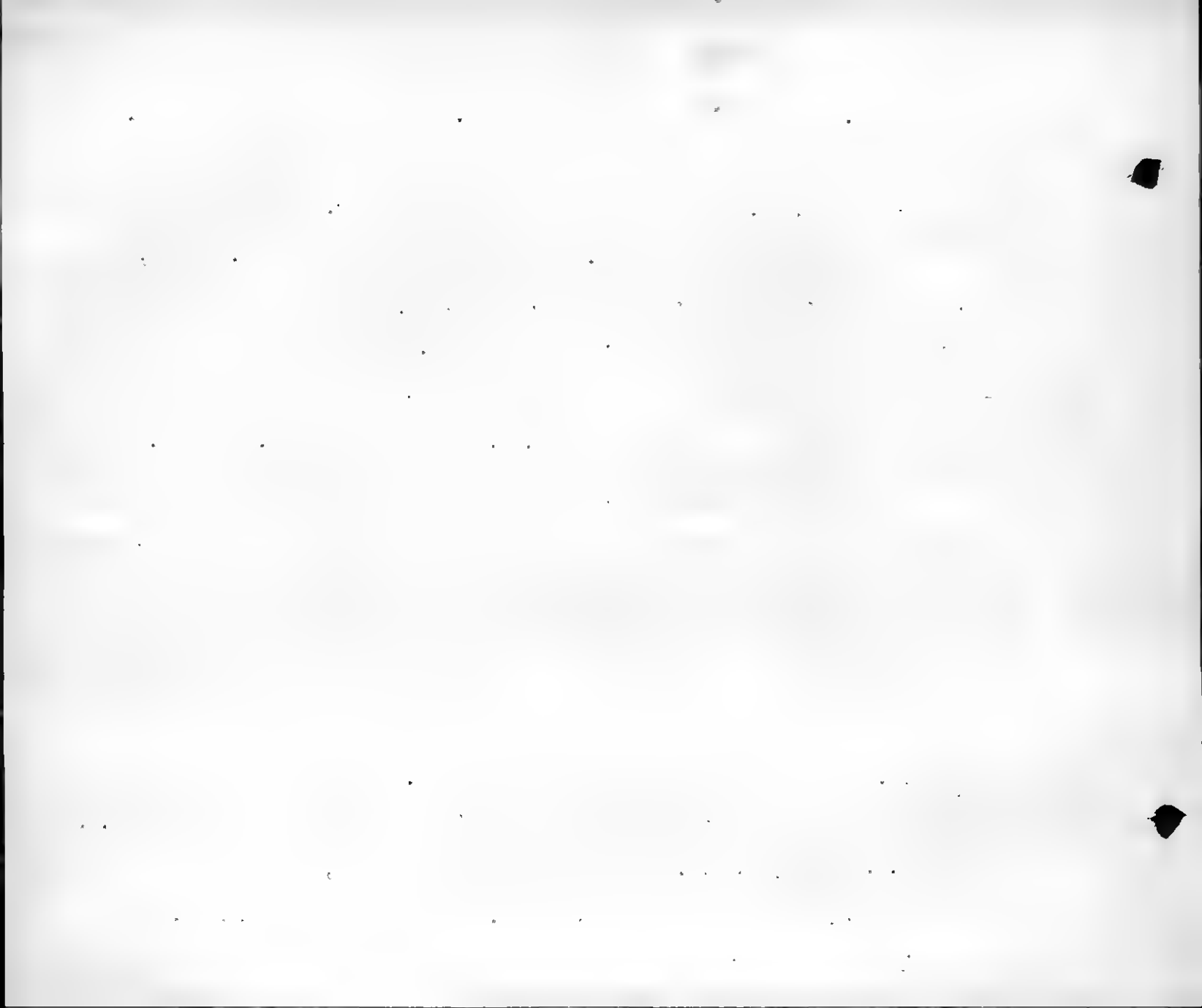
01598

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>505 Wilton Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LUCY</u> Middle <u>M.</u> Last <u>Davis</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>1,</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27, 1877</u>
9. AGE (In years last birthday) <u>82 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Christopher Marshaus</u>		14. MOTHER'S MAIDEN NAME <u>Unknown/ Henrietta Schesser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
INFORMANT <u>Mr. H. Leroy Davis - 505 Wilton Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Recurrent Carcinoma of the lung</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>13 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1959</u> to <u>Feb. 1, 1960</u> , that I last saw the deceased alive on <u>Feb. 1, 1960</u> , and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7215 York Road</u> DATE SIGNED <u>Feb. 3, 1960</u> ACTUAL SIGNATURE <u>S. J. Venable, Jr. M.D.</u> M.D. PHYSICIAN'S NAME (Type) <u>S. J. Venable, Jr. M.D.</u> <u>Baltimore 12, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL. (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/5/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. L. Tiekner &amp; Sons - Balto. 17.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 3 '60</u>	
ADDRESS <u>Baltimore 12, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Tiekner</u>	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



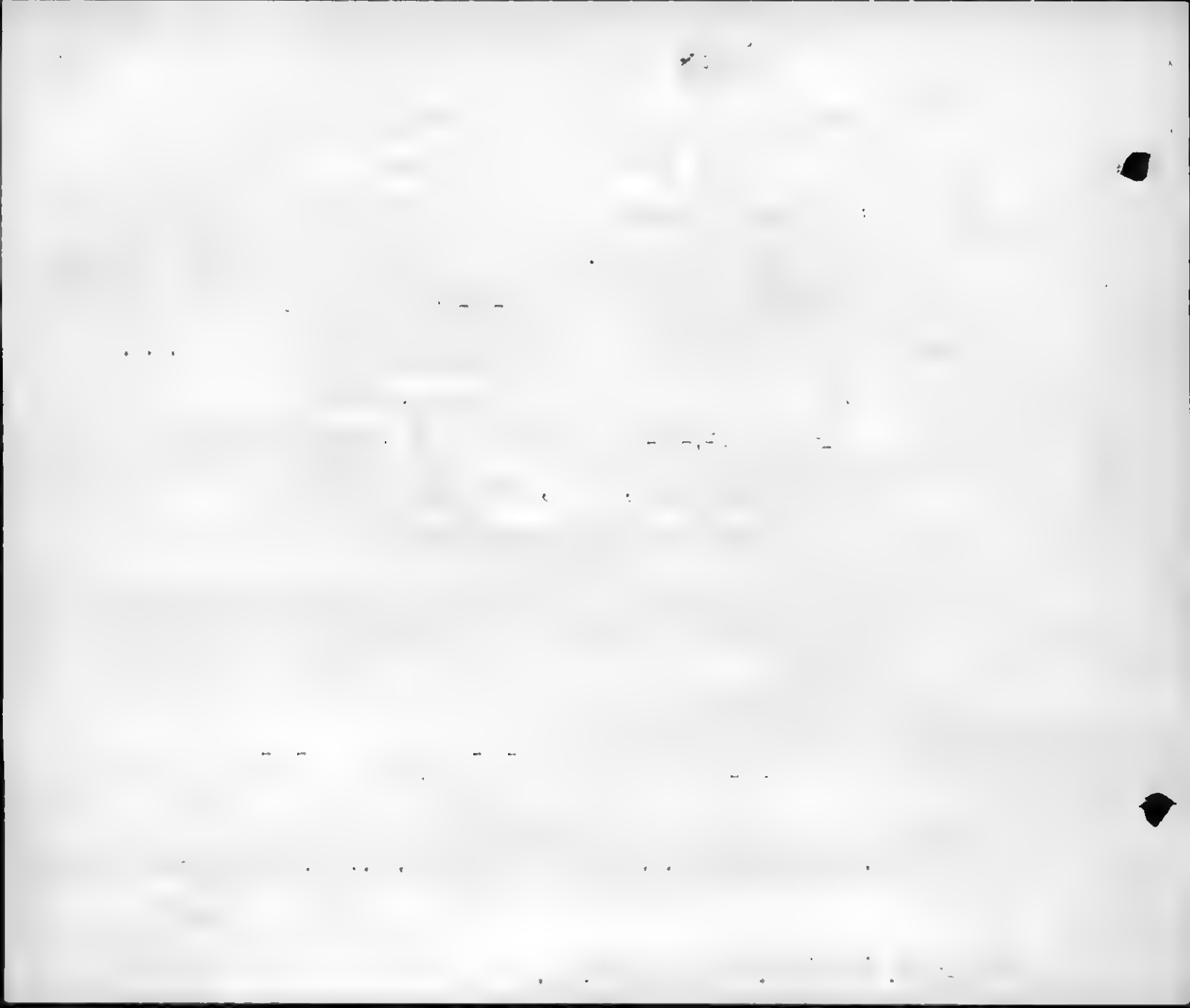
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1617 CERTIFICATE OF DEATH

01599

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Res-dence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>80 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MACK</b> Middle <b>J.</b> Last <b>DAVIS</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>12</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-10-97</b>
9. AGE (In years last birthday) <b>62</b> yrs		10. F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NORTH CAROLINA</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ANDREW DAVIS</b>		14. MOTHER'S MAIDEN NAME <b>PINKIE NICKELSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO <b>227-09-7724</b>	
17. INFORMANT <b>CLIN REC VAN BALTO MD FT HOWARD DIVISION</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ARRHYTHMIA, ACUTE, CAUSE UNDETERMINED</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>UNKNOWN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE; AORTIC INSUFFICIENCY DUE TO OLD LUETIC INVOLVEMENT</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12-24-59</b> to <b>2-12-60</b> , that (I) (we) lost saw the deceased alive on <b>2-12-60</b> 19, and that death occurred <b>2:05 pm</b> from the causes and on the date stated above.			
22a. SIGNATURE <i>George C. McElpatrick, M.D.</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>GEORGE C. MC ELPATRICK, M.D.</b>		22d. ADDRESS <b>VAN Balto, Md., Ft. Howard Division 2/13/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/17/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 17 '60</b>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraws</i>			

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1618  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
1618 CERTIFICATE OF DEATH

01600

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>3 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		d. STREET ADDRESS <b>1701 HARFORD RD</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ROSAMOND N. DEAL</b>		4. DATE OF DEATH Month Day Year <b>FEB 6 1960</b>	
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-27-1873</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JOHN W. BROWN</b>		14. MOTHER'S MAIDEN NAME <b>CECILIA J BARRANGER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Frank R. Smith Jr. - Cockeysville, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Cardio</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Vascular Disease</b> DUE TO (c) <b>3 years</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-26</b> 19 <b>57</b> to <b>2-5</b> 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>2-5</b> 19 <b>60</b> , and that death occurred at <b>4:35 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter T. Kees</b>		22b. DATE SIGNED <b>2/6/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>		22d. ADDRESS <b>Cockeysville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-9-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 8 '60</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Wm. S. Evans</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

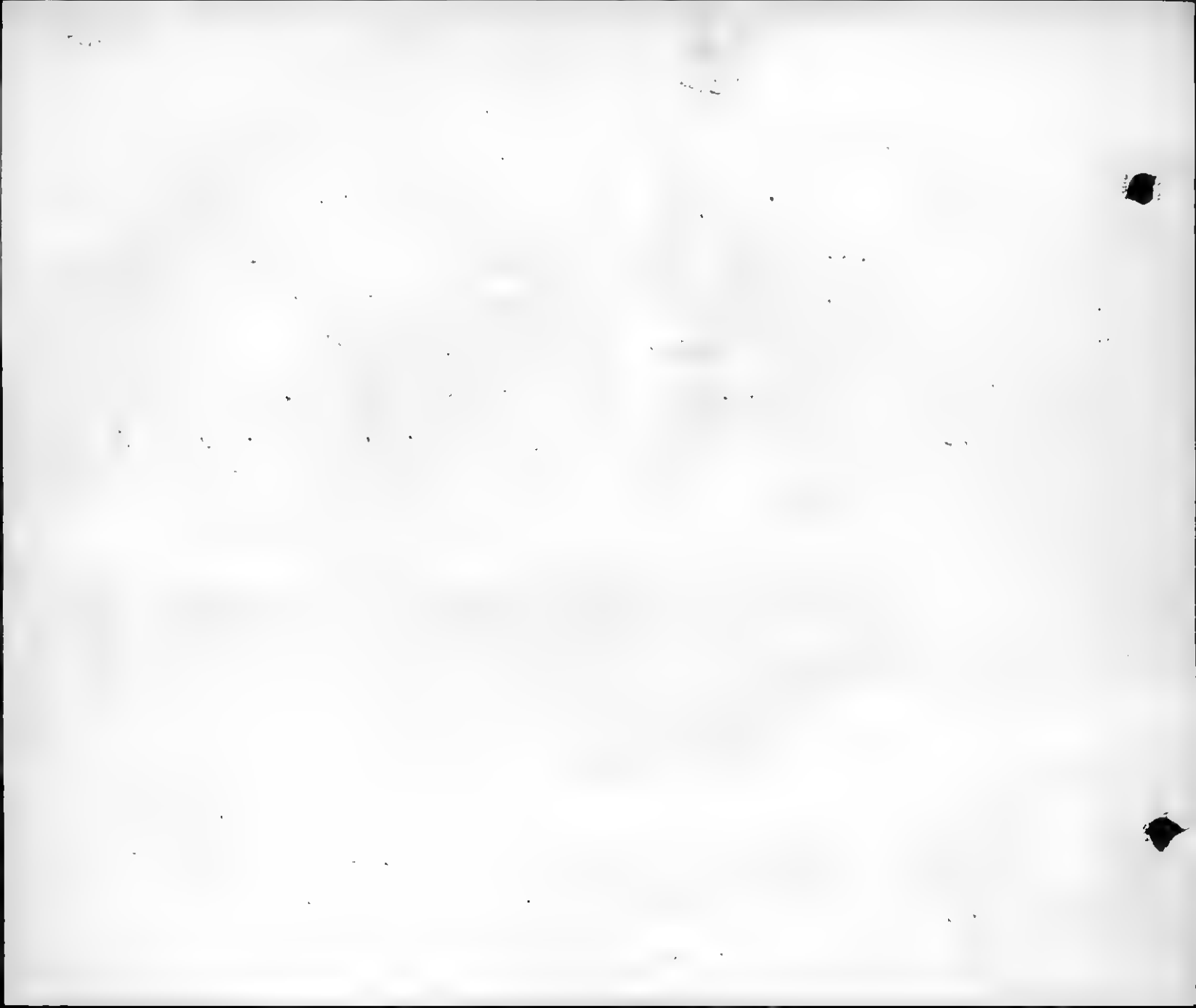
1618

## CERTIFICATE OF DEATH

01601

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Philadelphia Rd. Rt 7</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNE SHIRLEY DITZEL</u>		4. DATE OF DEATH Month Day Year <u>Feb 26 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 18-1925</u>
9. AGE (In years last birthday) <u>34</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Typist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Electric Co. Balto. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William J. Hersfeld.</u>		14. MOTHER'S MAIDEN NAME <u>Mildred R. Bryant</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-22-8477</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>193.0</u> DUE TO <u>Strokeytonia grade III right temporal lobe</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 2</u> , 19 <u>60</u> to <u>Feb 26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 26</u> , 19 <u>60</u> , and that death occurred at <u>6:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. E. Sobel MD</u>		ADDRESS (Street, city or town, state) <u>447 N. Kenwood Ave. Balto. Md.</u> DATE SIGNED <u>2/27/60.</u>	
PHYSICIAN'S NAME (Type) <u>L. E. Sobel MD</u>			
22a. BURIAL, CREMATION, REMOVALS (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-1-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. E. Sobel MD</u> ADDRESS <u>7401 Eglar Rd</u>		24a. REC'D BY REGISTRAR <u>MAR 1 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	





1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>1 Month</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>2832 St. Paul Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stella Maris Hospice</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Agnes</b> Middle <b>C.</b> Last <b>Donahue</b>				4. DATE OF DEATH Month <b>2</b> Day <b>22</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/6/1870</b>		9. AGE (In years lost birthday) <b>90 yrs</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) <b>Dressmaker (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas Donahue</b>				14. MOTHER'S MAIDEN NAME <b>Frances Hines</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>A. Madorah Donahue 2832 St. Paul Street</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4:11</b> DUE TO <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>15 yrs.</b> DUE TO (c) <b>15 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>15 yrs.</b>							
20a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>a. m.</b> Month <b>19</b> Day <b>19</b> Year <b>1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 29, 1960</b> to <b>Feb 22, 1960</b> that I last saw the deceased alive on <b>Feb 22, 1960</b> and that death occurred at <b>12:15</b> M, from the causes and on the date stated above ADDRESS (Street, City or town, state) <b>2501 Fair Rd Baltimore Md</b> DATE SIGNED <b>2/24/60</b>							
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.		PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell- M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 25, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. H. Meier &amp; Son - 805 N. Calvert St.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 23 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. J. Smith</b>	



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1603

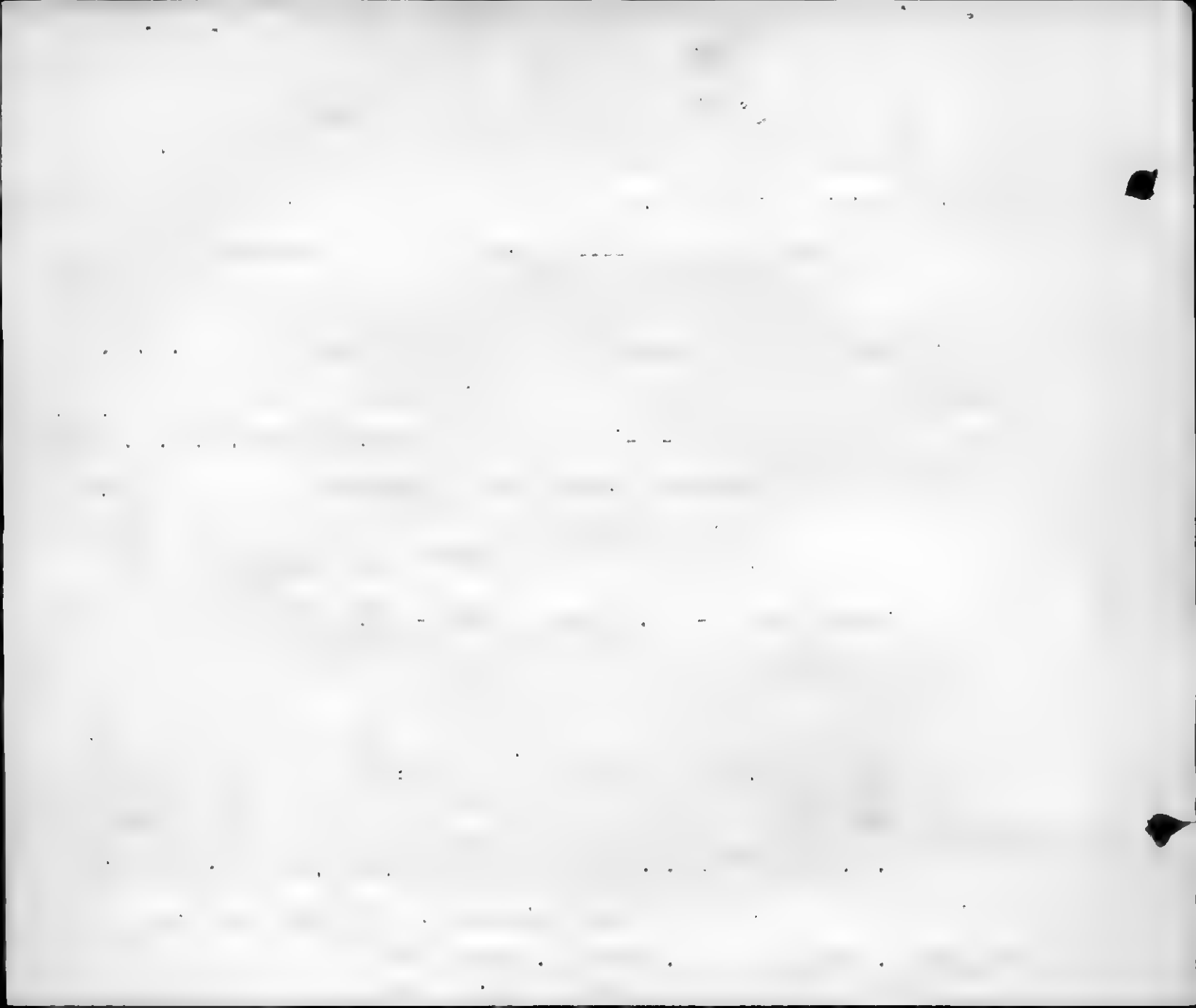
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1621 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>3 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE DOWNEY</b>				4. DATE OF DEATH Month Day Year <b>February 7 1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 15, 1898</b>	9. AGE (In years last birthday) yrs <b>61</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Friight Handler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transportation</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Samuel Downey</b>				14. MOTHER'S MAIDEN NAME <b>Louise Parker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 217-09-6995</b>		17. INFORMANT Address <b>Clinical Records, VAH, Balto. 18, Md. Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY INFARCTS, MULTIPLE, BILATERAL</b> <b>RHEUMATIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c), stating the underlying cause lost. <b>WITH CONGESTIVE HEART FAILURE AND AORTIC CALCIFIC VALVULITIS WITH STENOSIS</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Leiomyofibroma, stomach - old. Splenic infarct - old.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>OLD</b> <b>RECENT</b> <b>OLD</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that <b>W</b> (this hospital) attended the deceased from <b>Feb. 4</b> 19 <b>60</b> to <b>Feb. 7</b> 19 <b>60</b> , that <b>W</b> (we) last saw the deceased alive on <b>Feb. 7</b> 19 <b>60</b> , and that death occurred at <b>10:05 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>W. J. PIJANOWSKI</b>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>2/8/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>W. J. PIJANOWSKI, M.D.</b>		22d. ADDRESS <b>VAH, Balto. 18, Md. Fort Howard Division</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2/11/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>		ADDRESS <b>1808 N. Monroe St., Balto Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 15 '60</b>	25b. REGISTRAR'S SIGNATURE <b>W. J. PIJANOWSKI</b>		

TO HOSPITAL ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1622

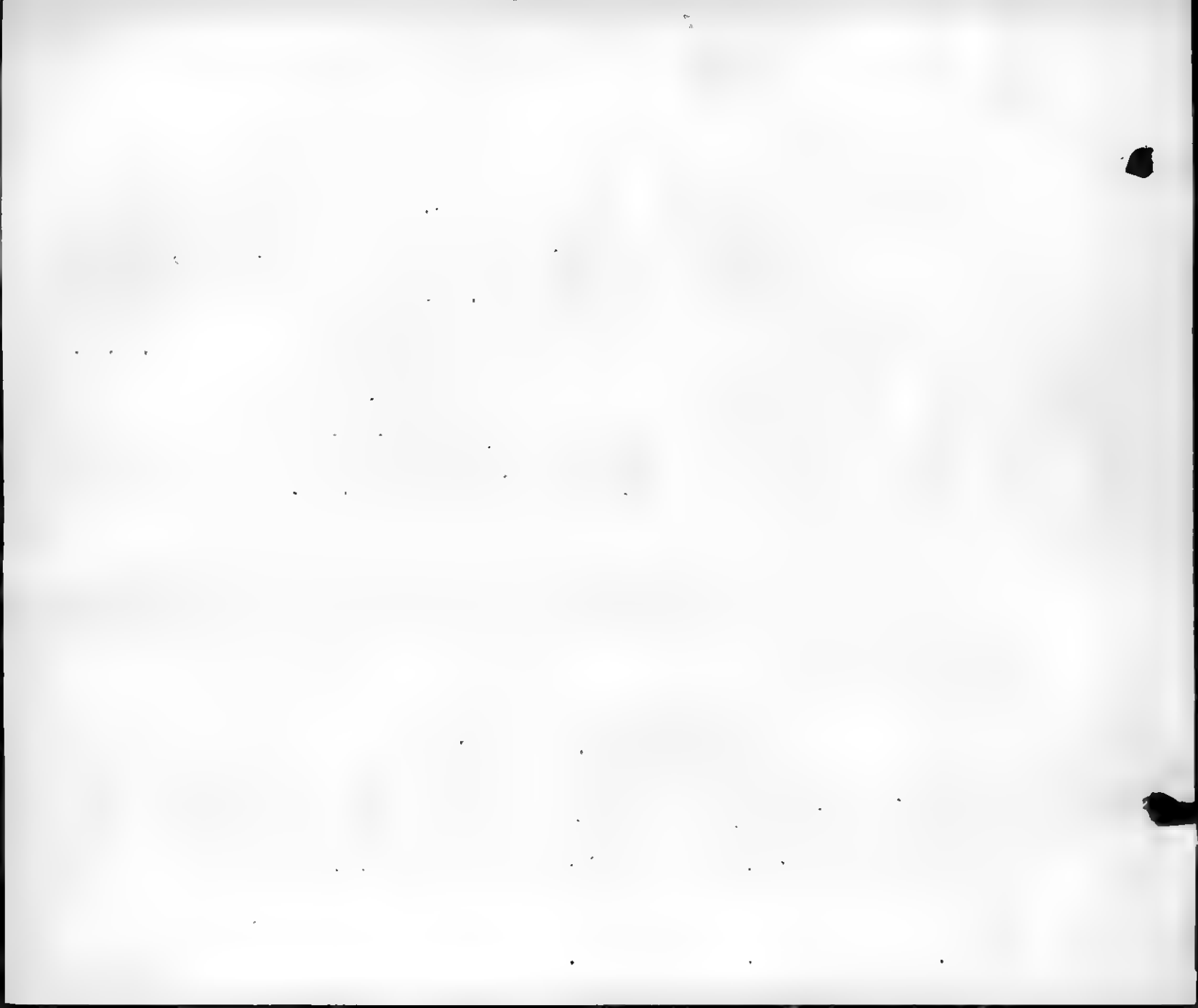
## CERTIFICATE OF DEATH

Reg. Dist. No.

01604

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>1mth5days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>1111 N. Luzerne Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Christopher</b> Last <b>Dudley</b>		4. DATE OF DEATH Month <b>February</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22, 1883</b>
9. AGE (In years last birthday) <b>76</b> yrs		10. IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min <b>76</b>	11. IF UNDER 24 HRS. Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min <b>76</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Richard Dudley</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Norton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-14-3400</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia (PNEUMONIA)</b> <b>41 X</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 17, 1960</b> to <b>FEB 21, 1960</b> ; that I lost saw the deceased alive on <b>FEB 21, 1960</b> , and that death occurred at <b>8:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED ACTUAL SIGNATURE <b>Anthony S. Spina M.D.</b> PHYSICIAN'S NAME (Type) <b>ANTHONY S. SPINA</b> Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE, THEREOF <b>Feb 24, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran</b>		24. REC'D BY REGISTRAR <b>FEB 25 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles E. Huns</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

01605

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>	
c. LENGTH OF STAY IN 1b <u>5 years</u>		d. STREET ADDRESS <u>3707 Ferndale Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood Training School</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nancy</u> Middle <u>Virginia</u> Last <u>Dunning</u>		4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-22-52</u>
9. AGE (In years last birthday) <u>8</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>8</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Md.</u>	
13. FATHER'S NAME <u>William Dale Dunning</u>		14. MOTHER'S MAIDEN NAME <u>Carol Helen Snyder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Rosewood Records</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute and chronic, bilateral</u> <u>471X</u> DUE TO <u>bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>—</u> , 19 <u>—</u> to <u>—</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>—</u> , 19 <u>—</u> , and that death occurred at <u>10:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter W. Rieckert</u> M.D.		ADDRESS (Street, city or town, state) <u>4307 Mainfield Ave E-22-60</u>	
PHYSICIAN'S NAME (Type) <u>Peter W. Rieckert</u>		Baltimore 14, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/27/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Lieberman &amp; Sons - Balt</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>FEB 29 '60</u>		DATE <u>—</u>	

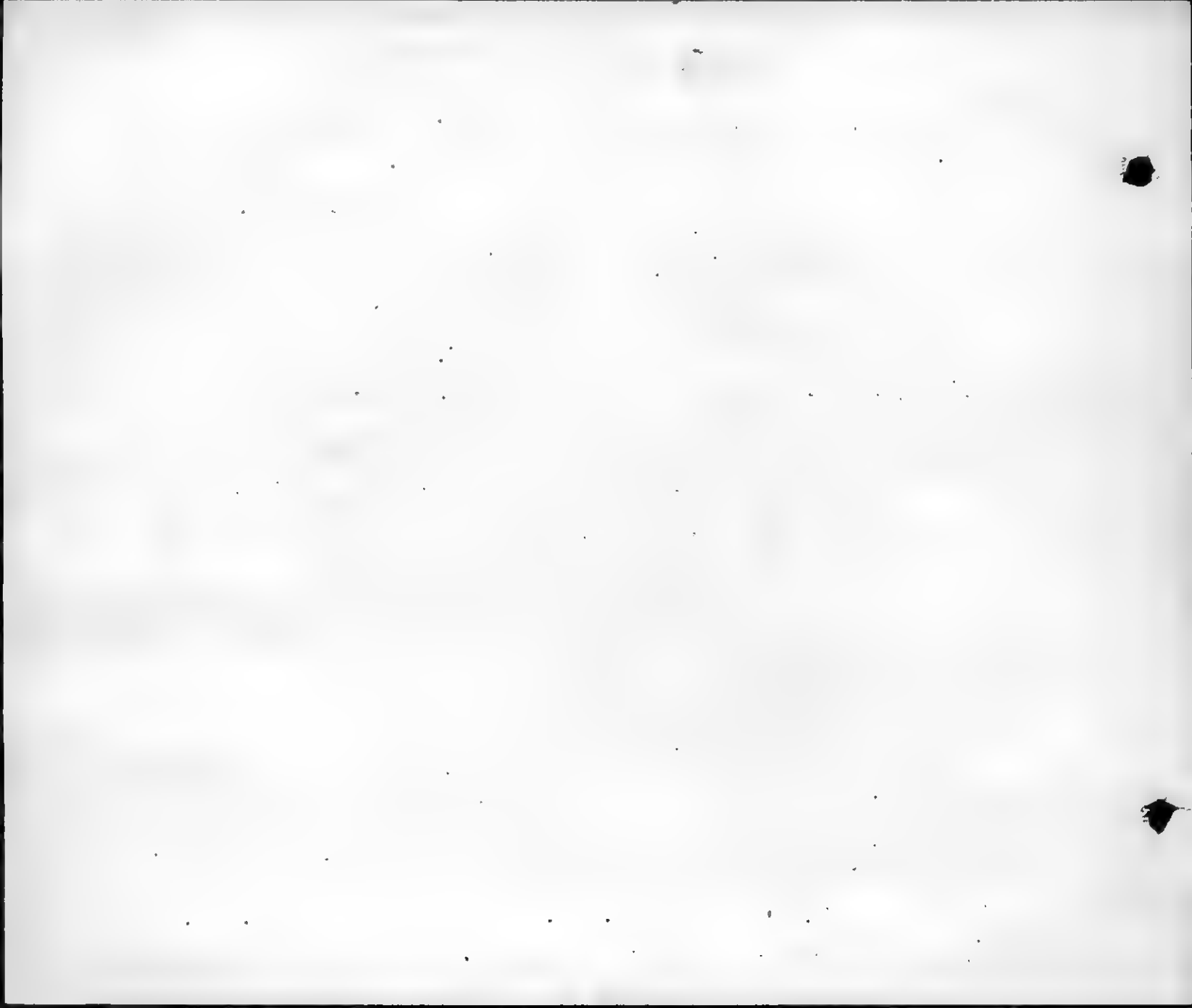
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Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

Reg. Dist. No.

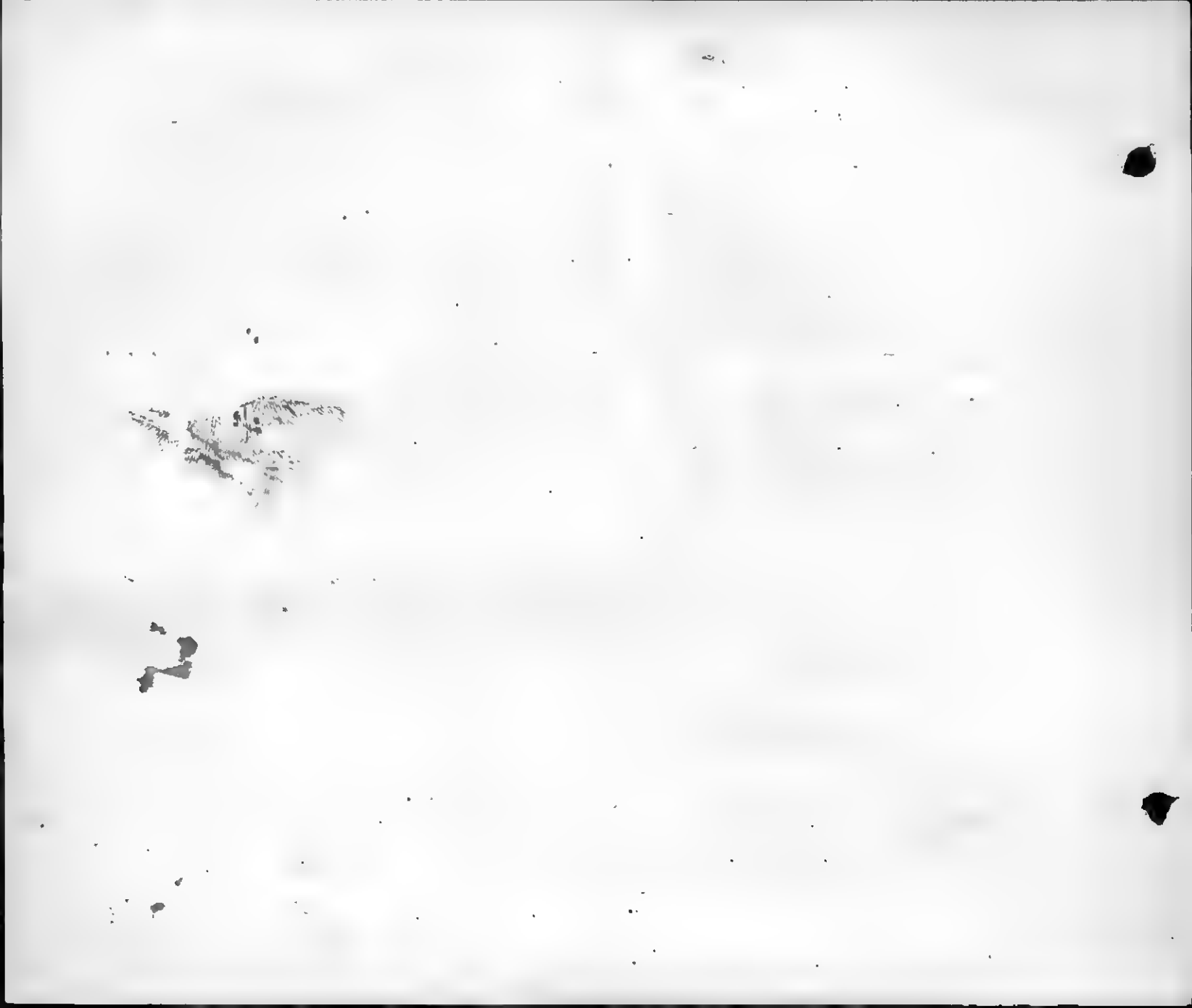
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural near Towson</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Villa Maria</b>		d. STREET ADDRESS <b>Glenarm Rd.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sr. M. Renata Durra</b>		4. DATE OF DEATH Month Day Year <b>Feb. 13 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 13, 1871</b>
9. AGE (In years last birthday) <b>88</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RELIGIOUS</b>	
11. BIRTHPLACE (State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Anton Durra</b>		14. MOTHER'S MAIDEN NAME <b>Anastasia Zach</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Sr. Mary Clara</b>		Address <b>Notch Cliff, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Coronary renal vascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Feb. 5, 1951, to Feb. 3, 1960</b> , that I last saw the deceased alive on <b>Jan. 26, 1960</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>7501 York Rd. Towson 4, Md.</b> DATE SIGNED <b>2/3/60</b>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		PHYSICIAN'S NAME (Type) <b>CHARLES F. O'DONNELL</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-6-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>VILLA MARIA CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>NOTCH CLIFF NE TOWSON, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Guler</b>		24a. REC'D BY REGISTRAR <b>DATE 8 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>William S. [unclear]</b>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01608

1626 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>2 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New York</b> <b>69x</b>	
3. NAME OF DECEASED (Type or print) First <b>RUDOLPH</b> Middle <b>N.</b> Last <b>EARL</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>6TH</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/9/24</b>
9. AGE (In years last birthday) <b>36</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Washer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Car Washing</b>	
11. BIRTHPLACE (State or foreign country) <b>Prospect, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Earl</b>		14. MOTHER'S MAIDEN NAME <b>Cornelia Franklin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>213-18-7679</b>	
17. INFORMANT <b>Clin. Rec. VAH, Balto. Md. Ft. Howard Division</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INANITION</b> <b>161X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>EPIDERMOID CARCINOMA OF LARYNX WITH METASTASIS</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>APPROX. 1 YEAR</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>1/1</b> (this hospital) attended the deceased from <b>Feb. 4th 1960</b> to <b>Feb. 6th 1960</b> , that <b>1/1</b> (we) last saw the deceased alive on <b>Feb. 6 1960</b> , and that death occurred at <b>4:50 PM</b> from the causes and on the date stated above			
22a. SIGNATURE <b>L. Bruce Smith</b>		22b. DATE SIGNED <b>2/7/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. BRUCE SMITH, M.D.</b>		22d. ADDRESS <b>VAH, BALTIMORE, MD. FT. HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/10/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>		25a. REC'D BY REGISTRAR <b>FEB 11 '60</b>	
ADDRESS <b>1808-10 N. Monroe St. Baltimore 17, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

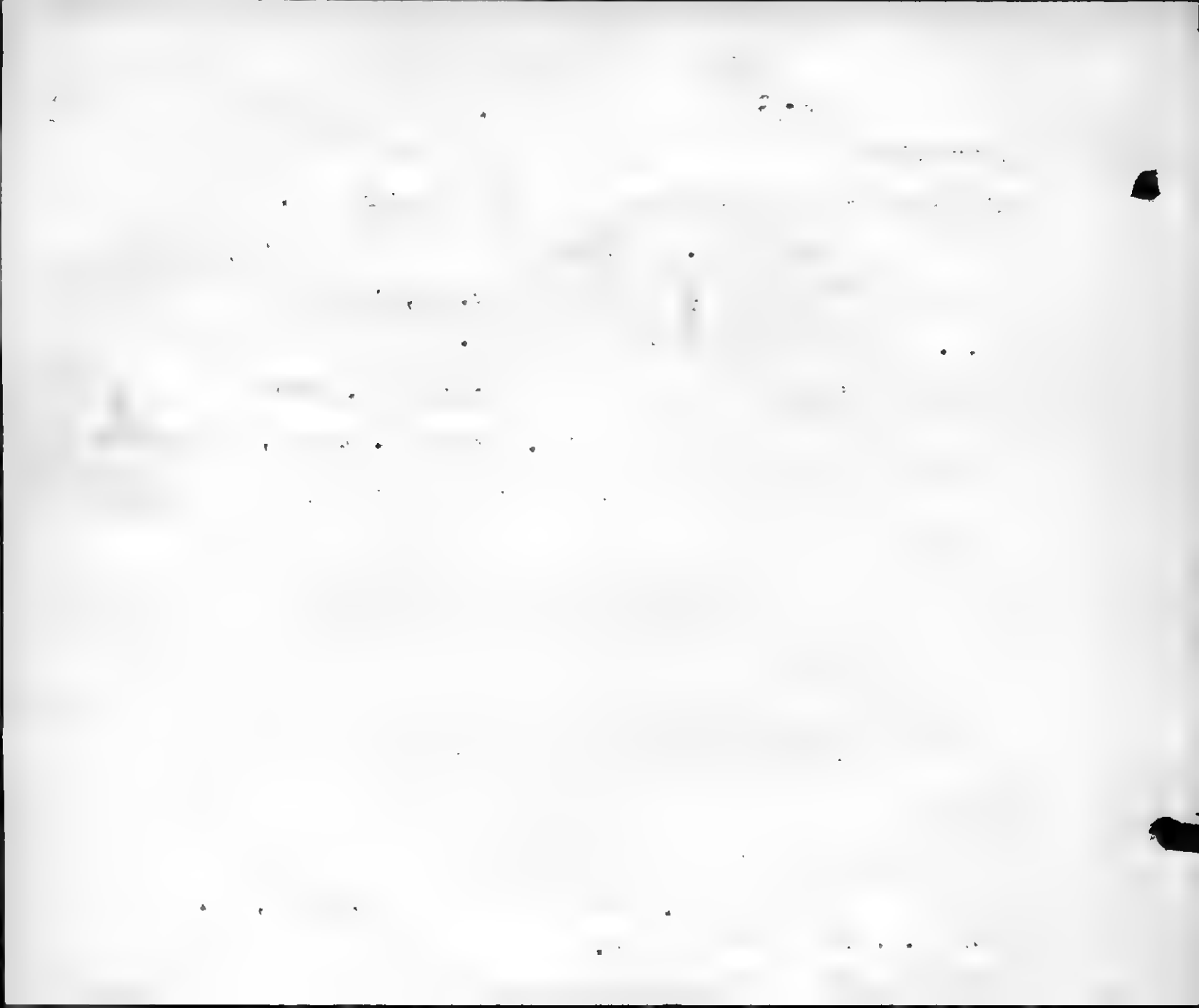


1627

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>21 1/4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor Nursing Home</b>		d. STREET ADDRESS <b>810 Stamford Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Rosa B. Eaton</b>		4. DATE OF DEATH Month <b>2</b> Day <b>17</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 18, 1873</b>
9. AGE (In years last birthday) <b>86</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Allen Ledwidge</b>		14. MOTHER'S MAIDEN NAME <b>Margaret A. Trent</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>Mrs. Charles E. Compher, 810 Stamford Rd</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis (arterio-sclerosis)</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>NO</b> DUE TO (c) <b>NO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NO</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 12, 1960</b> to <b>Feb 17, 1960</b> ; that I last saw the deceased alive on <b>Feb 16, 1960</b> , and that death occurred at <b>7:10 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Woodsboro, Md.</b> DATE SIGNED <b>Feb 23 '60</b>			
ACTUAL SIGNATURE <b>J. P. ...</b> M.D.			
PHYSICIAN'S NAME (Type) <b>J. P. ...</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/20/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope</b>		22d. LOCATION (City, town, or county) (State) <b>Woodsboro, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. F. D. 4101 Edmondson Ave.</b>		24. REC'D BY REGISTRAR <b>FEB 23 '60</b>	
25. REGISTRAR'S SIGNATURE <b>Arthur E. ...</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1628

## CERTIFICATE OF DEATH

Reg. Dist. No.

01610

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Joppa</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Joppa</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rt. 2 Joppa Md.</b>		d. STREET ADDRESS <b>Rt. 2 Joppa Md.</b>	
3. NAME OF DECEASED (Type or print) First <b>Fitzhugh</b> Middle <b>L.</b> Last <b>Edwards</b>		4. DATE OF DEATH Month <b>February</b> Day <b>5</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 9, 1887</b>
9. AGE (In years last birthday) <b>73</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min <b>73</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Augusta Fitzhugh</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Tate</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>218-01-1756</b>	
INFORMANT <b>Mrs Virginia Simms</b>		Address <b>Rt #2 Joppa Md.</b>	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 4430 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Dis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b> <b>74 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>7:21</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/21</b> , 19 <b>58</b> , to <b>2/5</b> , 19 <b>60</b> that I last saw the deceased alive on <b>2/5</b> , 19 <b>60</b> and that death occurred at <b>5:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clifford F. Hudson</b> M.D.		ADDRESS (Street, city or town, state) <b>FORK, MD.</b>	
PHYSICIAN'S NAME (Type) <b>CLIFFORD F. HUDSON</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-9-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clifford F. Hudson</b>		24a. REC'D BY REGISTRAR <b>FEB 10 '60</b>	
ADDRESS <b>2741 B... ..</b>		24b. REGISTRAR'S SIGNATURE <b>Clifford F. Hudson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13

1629

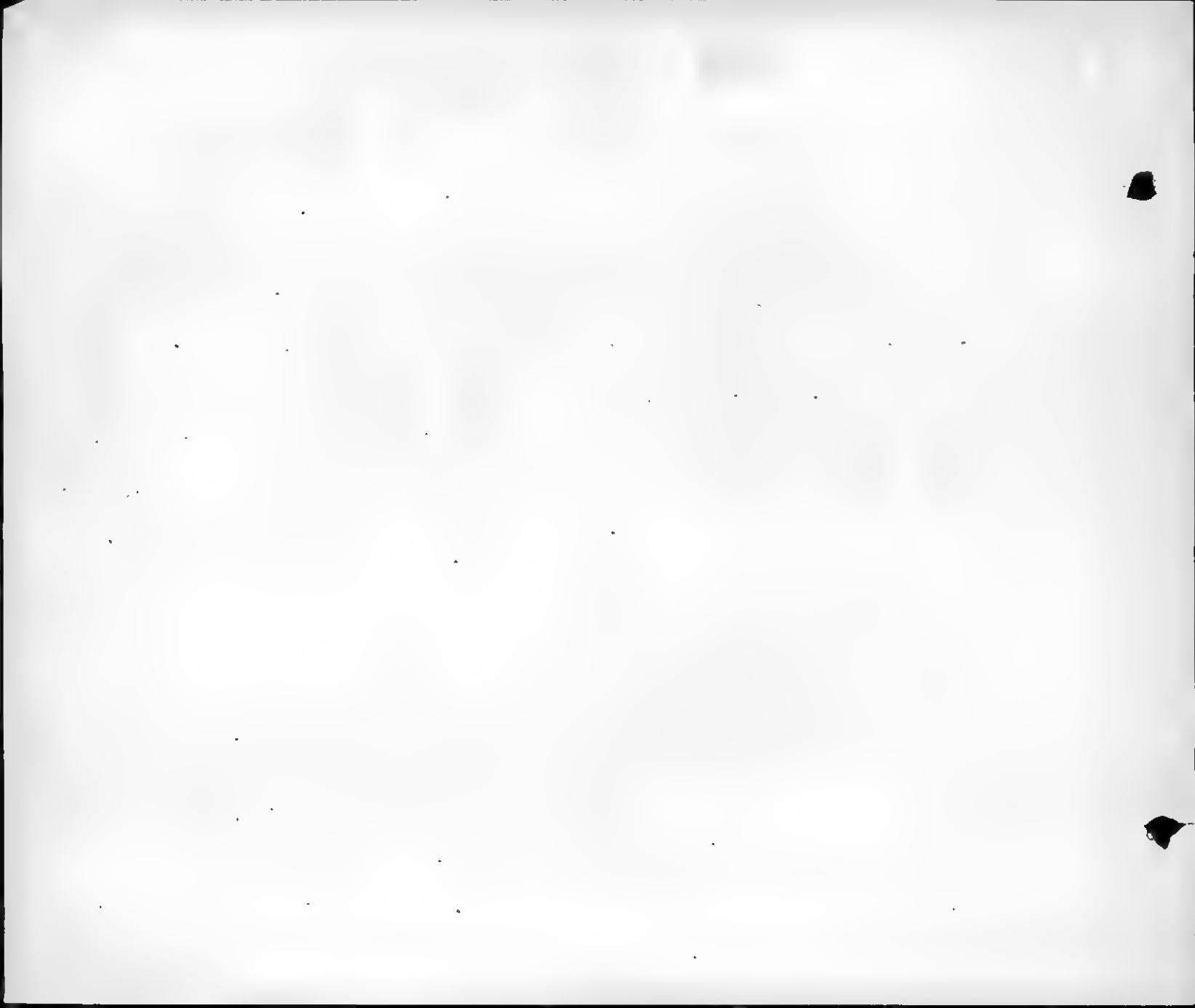
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b <u>1 WEEK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUMMIT NURSING HOME</u>				d. STREET ADDRESS <u>2560 WILKENS AVE</u>			
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>ENGLEHARDT</u> Last <u>ENGLEHARDT</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 26, 1888</u>	
9. AGE (In years last birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>METAL SMITH</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL FABR</u>			
13. FATHER'S NAME <u>HENRY ENGELHARDT</u>				14. MOTHER'S MAIDEN NAME <u>BARBARA YEAGER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>215-10-2162</u>			
17. INFORMANT <u>HARRY DAUGHERTY</u>				Address <u>CEAR HILL Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute coronary insufficiency</u> DUE TO <u>Atherosclerotic coronary disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11:30</u> , 19 <u>59</u> , to <u>2:20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1</u> , 19 <u>60</u> , and that death occurred at <u>6:20</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Justina Kurinka</u> M.D.				ADDRESS (Street, city or town, state) <u>2151 Wilkens Ave Baltimore, Md</u>			
PHYSICIAN'S NAME (Type) <u>Justina Kurinka</u>				DATE <u>2-2-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-5-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>TACKWOOD MEMORIAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO County Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. E. Schwab Funeral Home</u> ADDRESS <u>Princeton St. Miller 2101 Frederick Ave. Balt.</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1630

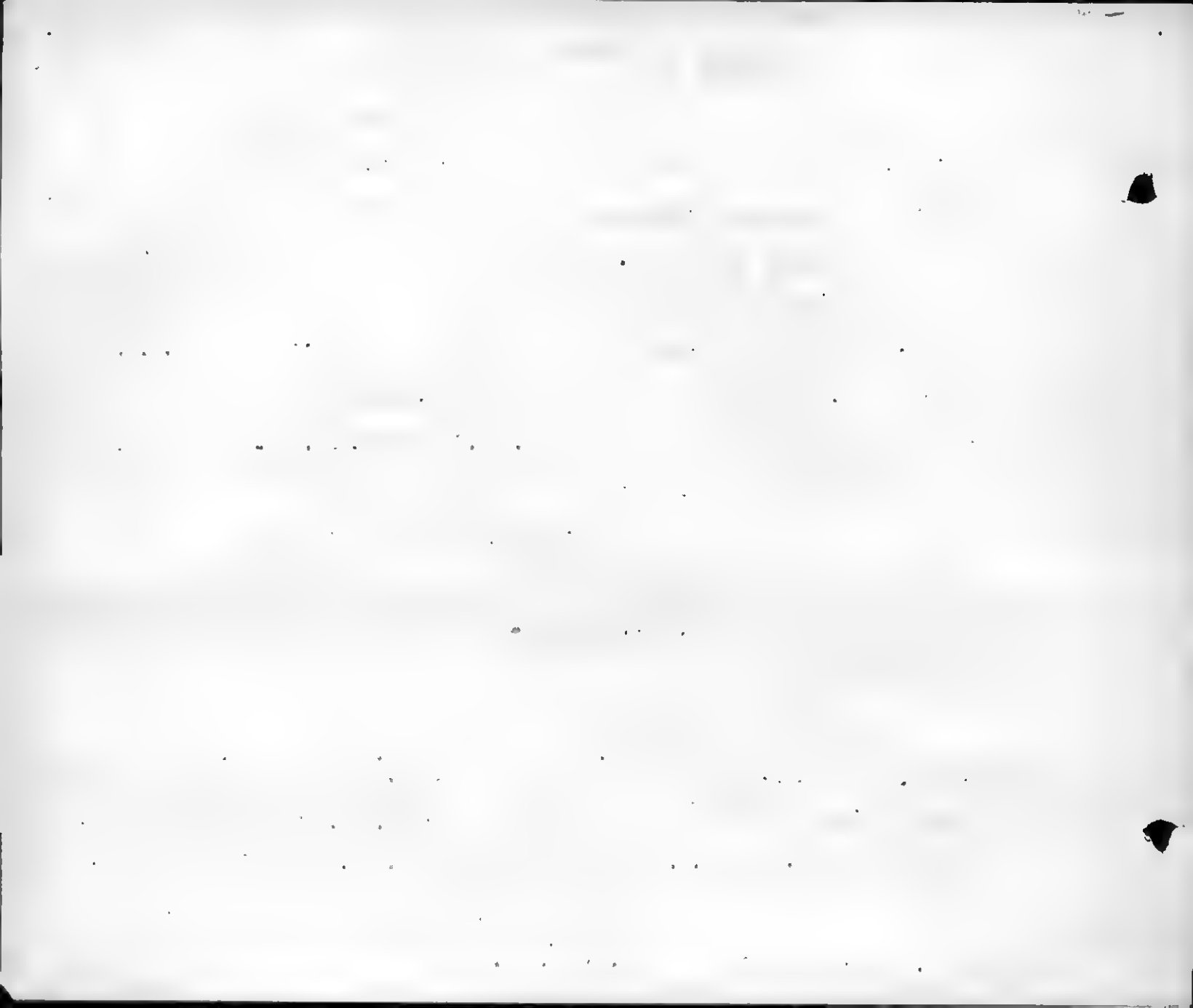
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>4 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Baltimore</b>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>A.</b> Last <b>FAUTH</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>27</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/18/95</b>
9. AGE (In years last birthday) <b>65</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Jobber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Candy</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles A. Fauth</b>		14. MOTHER'S MAIDEN NAME <b>Mary Humphrey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>	
17. INFORMANT <b>Clin. Rec. VAH, Balto. Md. Ft. Howard Division</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR FAILURE</b> <b>210X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b> DUE TO (c) <b>DIABETES MELLITUS</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>6 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>JAUNDICE DUE TO UNDIAGNOSED LIVER DISEASE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 23, 1960</b> , to <b>Feb. 27, 1960</b> , and that death occurred at <b>12:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Charles Allen</b>		M.D. <b>VAH, BALTO. MD. FORT HOWARD DIVISION</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES ALLEN, M.D.</b>		<b>VAH, BALTO. MD. FORT HOWARD DIVISION 2/27/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-2-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>George A. Farley Funeral Home</b>		24. REC'D BY REGISTRAR <b>Frederick &amp; Shady Nook Ave. Balto. Md.</b> DATE <b>MAR 2 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Christina S. Hanna</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



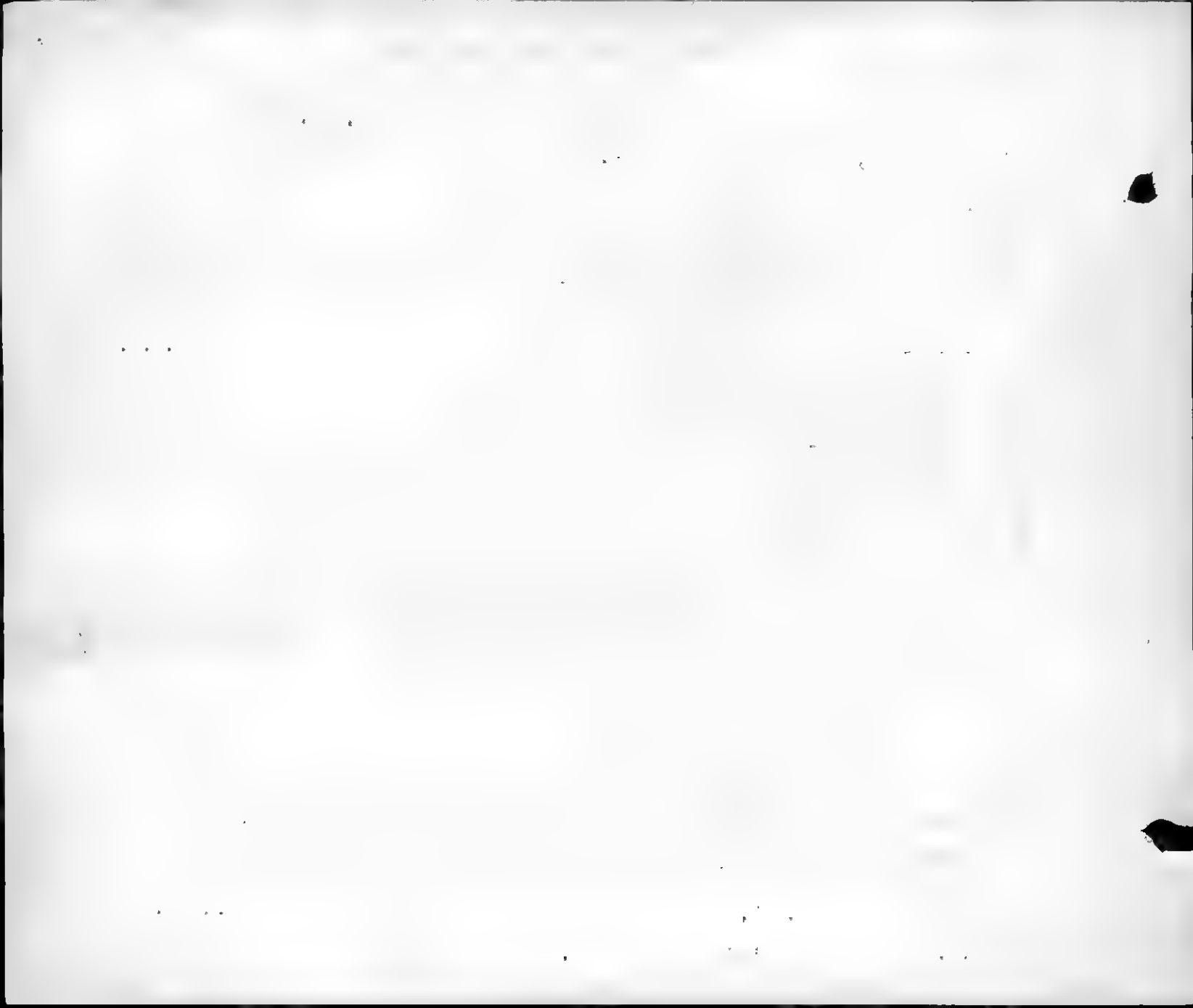
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1631 CERTIFICATE OF DEATH

Reg. Dist. No. 01613

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Baltimore, Md.</b> b. COUNTY <b>City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>		d. STREET ADDRESS <b>301</b>	
3. NAME OF DECEASED (Type or print) First <b>Harrison</b> Middle <b>Walker</b> Last <b>Fincher</b>		4. DATE OF DEATH Month <b>2</b> Day <b>23</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/11/42</b>
9. AGE (In years last birthday) <b>18</b> yrs.		10. IF UNDER 1 YEAR Months <b>18</b> Days <b>18</b> Hours <b>18</b> Min <b>18</b>	11. IF UNDER 24 HRS. Months <b>18</b> Days <b>18</b> Hours <b>18</b> Min <b>18</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Denkins</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Fincher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>---</b>	
17. INFORMANT <b>Rosewood Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b> <b>491X</b> DUE TO <b>with abscess formation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>---</b> DUE TO <b>---</b> (c) <b>---</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sporadic quadriplegia</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>---</b> o. m. <b>---</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>---</b> , 19 <b>---</b> , to <b>---</b> , 19 <b>---</b> , that I last saw the deceased alive on <b>---</b> , 19 <b>---</b> , and that death occurred at <b>8:00a</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Peter W. Rieckert</b>		ADDRESS (Street, city or town, state) <b>4307 Mainfield Ave</b>	
PHYSICIAN'S NAME (Type) <b>Peter W. Rieckert</b>		DATE SIGNED <b>2-23-60</b>	
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 26, 60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rosewood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Owings Mills, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons</b>		ADDRESS <b>Reisterstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>---</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	
DATE <b>FEB 29 1960</b>			

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film 6257 2-27-60 et

01614

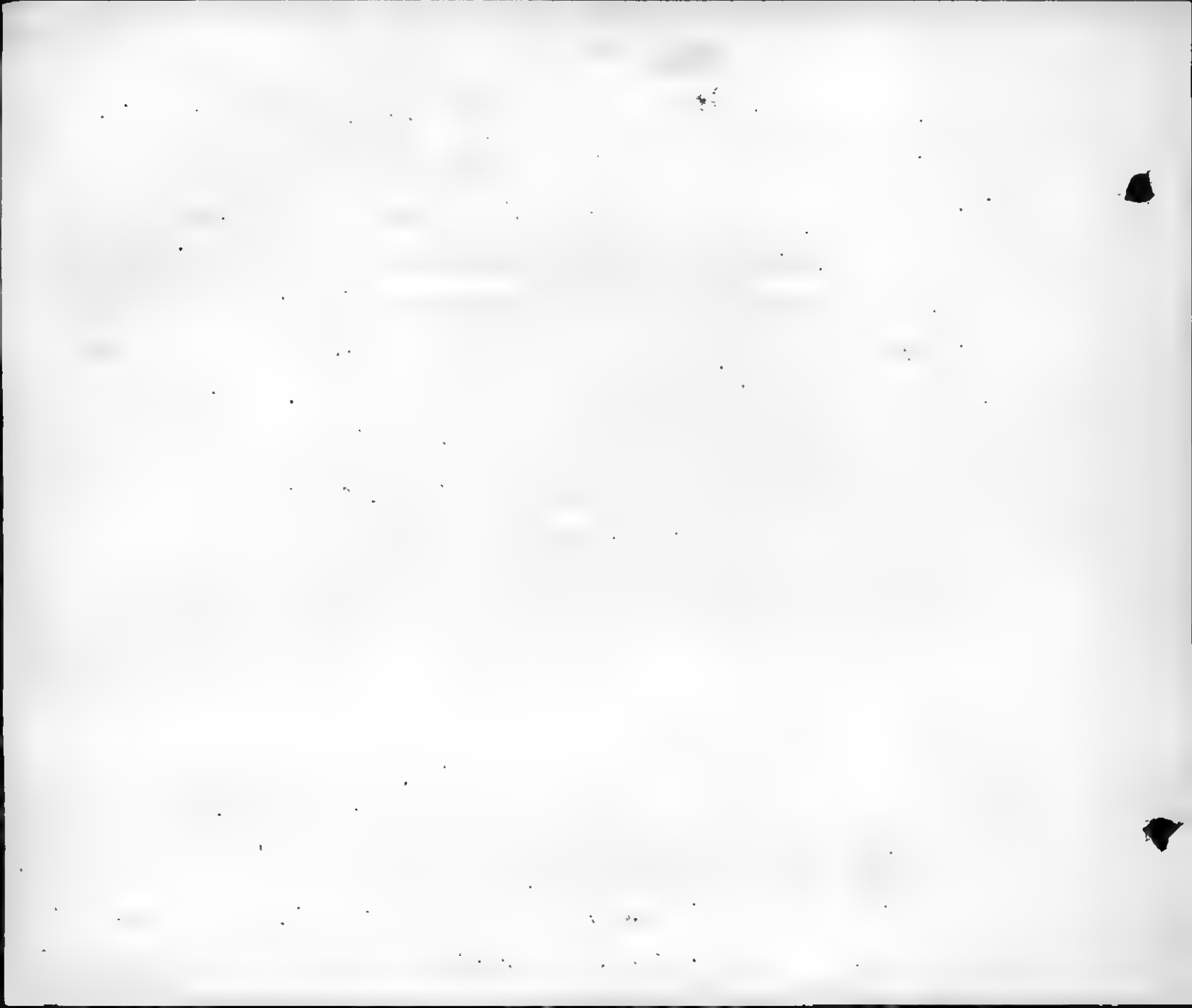
## 1632 CERTIFICATE OF DEATH

Reg. Dist. No.

Page 4

The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filled with the burial-transit permit. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS Mills</u>		c. LENGTH OF STAY IN 1b <u>17 YRS.</u> <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>510 ROSEWOOD STATE TRAINING SCHOOL</u>		d. STREET ADDRESS <u>8219 BELAIR ROAD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROBERT LEE FOSTER</u>		4. DATE OF DEATH Month Day Year <u>FEBRUARY 15 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <u>138</u> 9. AGE (In years last birthday) <u>22</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>WALTER J. FOSTER</u>	
14. MOTHER'S MAIDEN NAME <u>MARY EVELYN MULL</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>ROSEWOOD RECORDS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u> DUE TO (b) <u>with empyema of Rt. pleural</u> DUE TO (c) <u>cavity</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home farm factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>12</u> , and that death occurred at <u>7:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Pete W. Rieckert</u> M.D.		ADDRESS (Street, city or town, state) <u>4307 Malfield Ave</u> DATE SIGNED <u>Baltimore 14, MO</u>	
PHYSICIAN'S NAME (Type) <u>Pete W. Rieckert</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Feb 19 60</u>	
22b. DATE THEREOF <u>Feb 19 60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Krider Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Rural, Westminster Md</u>		22e. (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr. Westminster, Md</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>FEB 23 '60</u>		Continued on Page 2	



## CERTIFICATE OF DEATH

Reg. Dist. No.

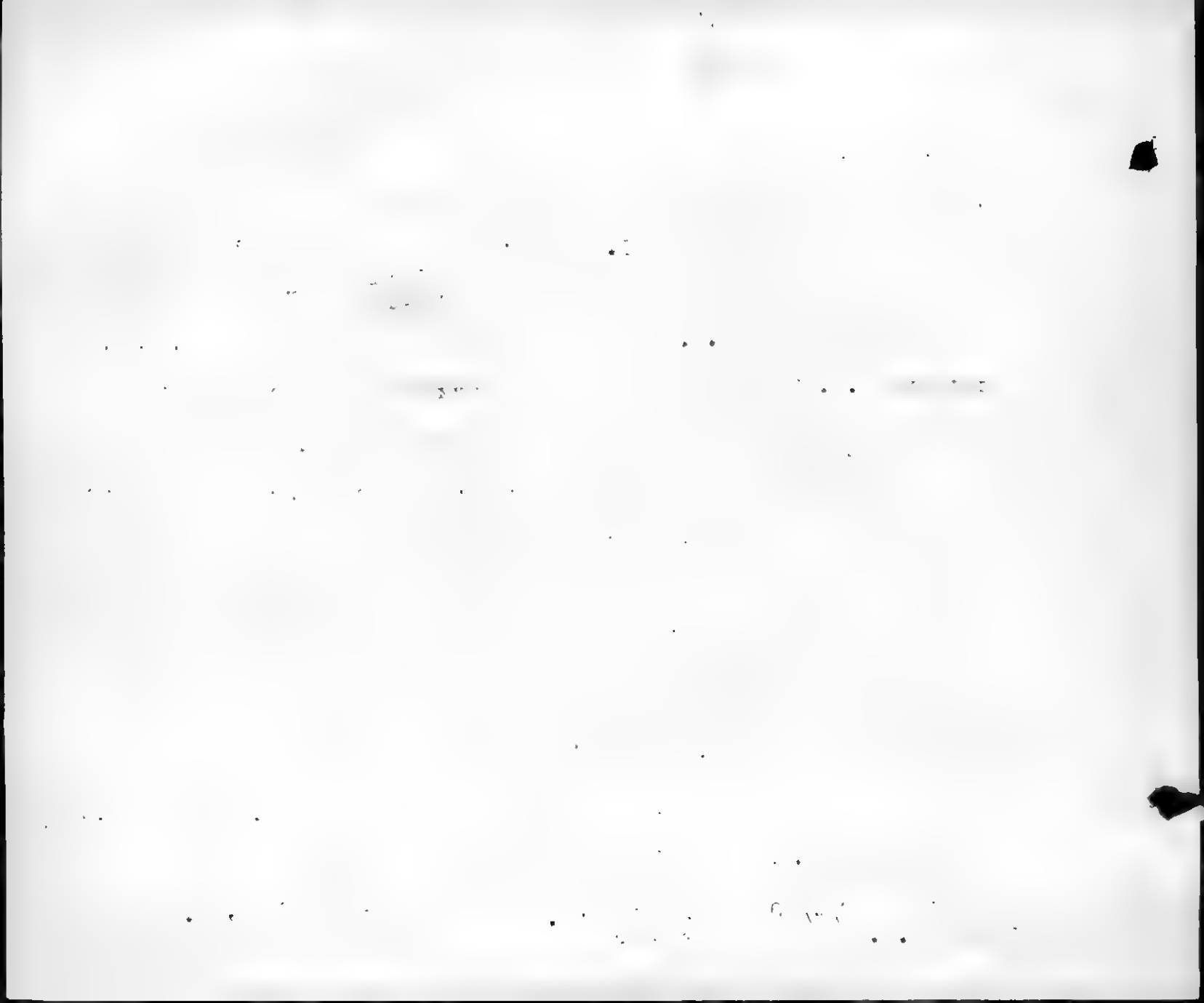
01615

1633

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b>	
c. LENGTH OF STAY IN 1b <b>days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>3410 West Franklin Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Agnes</b> Middle <b>I.</b> Last <b>Fox</b>		4. DATE OF DEATH Month <b>2</b> Day <b>6</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1881</b> <b>July 20, 1881</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>O.H.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <del>UNKNOWN</del> <b>F.W. Fox</b>		14. MOTHER'S MAIDEN NAME <del>UNKNOWN</del> <b>Lucinda Watkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>Jan. 29</b> , 19 <b>60</b> , to <b>2/6</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>2/6</b> , 19 <b>60</b> , and that death occurred at <b>7:20 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>2/6/60</b>			
ACTUAL SIGNATURE <b>Bruno Radauskas</b> M.D.		PHYSICIAN'S NAME (Type) <b>BRUNO RADAUSKAS</b> Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/9/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Pk.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore 7, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witke F.D.</b>		24a. REC'D BY REGISTRAR <b>FEB 9 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



01616

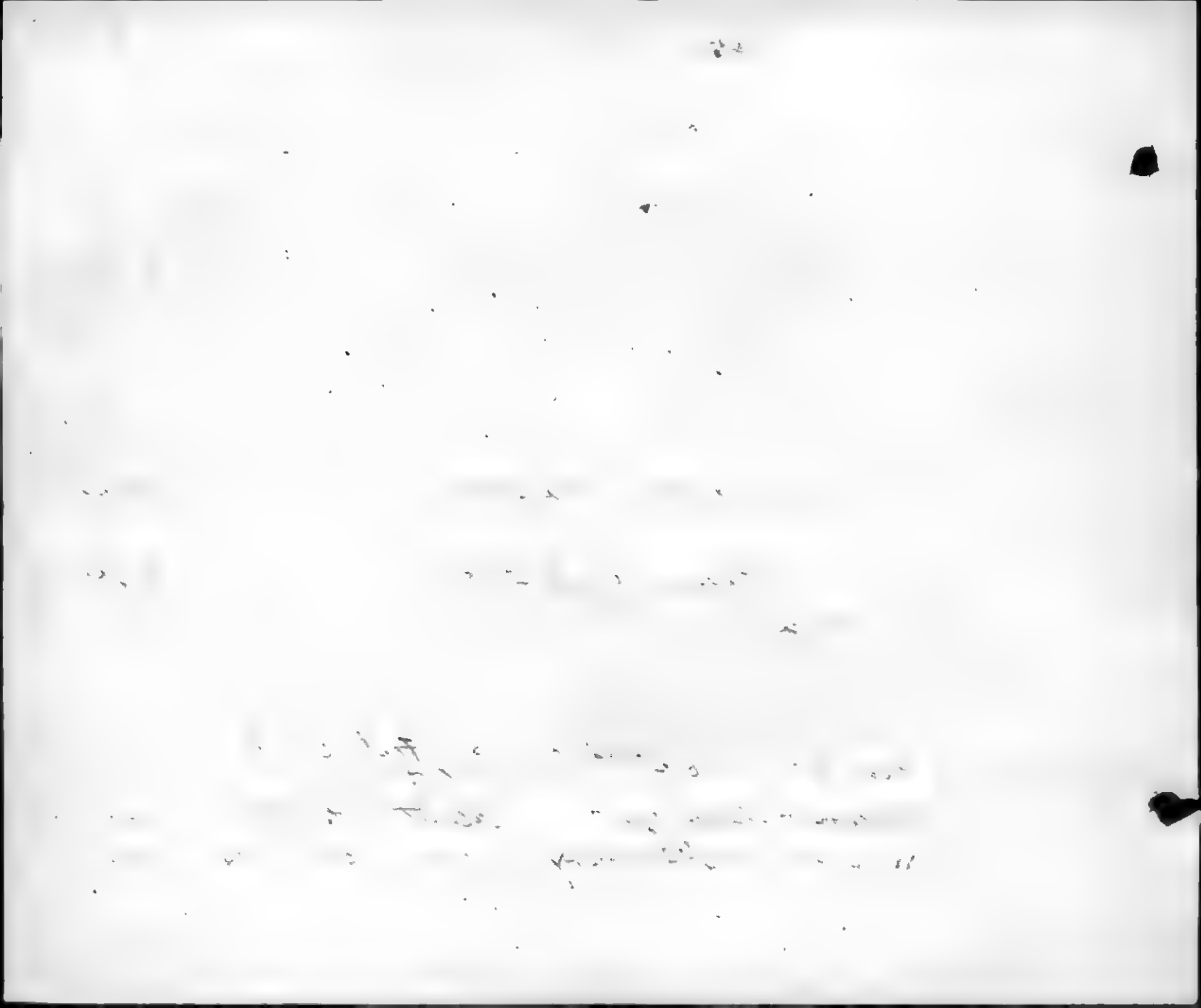
Reg. Dist. No.

**TO HOSPITAL ON RECOMMENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

YS A1S (4)  
15M 9/58

**DEPUTY FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE 28</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2317 Old Frederick Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROBERT EDWARD FRANCE</b>		4. DATE OF DEATH <b>FEBRUARY 6, 1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 22, 1884</b>
9. AGE (In years last birthday) <b>76 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
3. FATHER'S NAME <b>THEODORE FRANCE SR.</b>		14. MOTHER'S MAIDEN NAME <b>CHRISTINE IMHOFF</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-09-6254</b>	
17. INFORMANT <b>MRS. ELIZABETH FRANCE</b>		Address <b>2317 Old Frederick Rd. Catonsville 28, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>156.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Carcinoma of Liver</b> DUE TO (c) <b>2 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 4, 1958</b> , to <b>Feb 6, 1960</b> , that I last saw the deceased alive on <b>Feb 5, 1960</b> , and that death occurred at <b>1 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William F. Gassaway</b> M.D. <b>Ellicott City, Md.</b>		DATE SIGNED <b>2-6-60</b>	
PHYSICIAN'S NAME (Type) <b>WILLIAM F. GASSAWAY</b>		<b>Ellicott City, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/9/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHN'S CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Sons, Catonsville 28, Md.</b>		24. REC'D BY REGISTRAR <b>FEB 9 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



1635

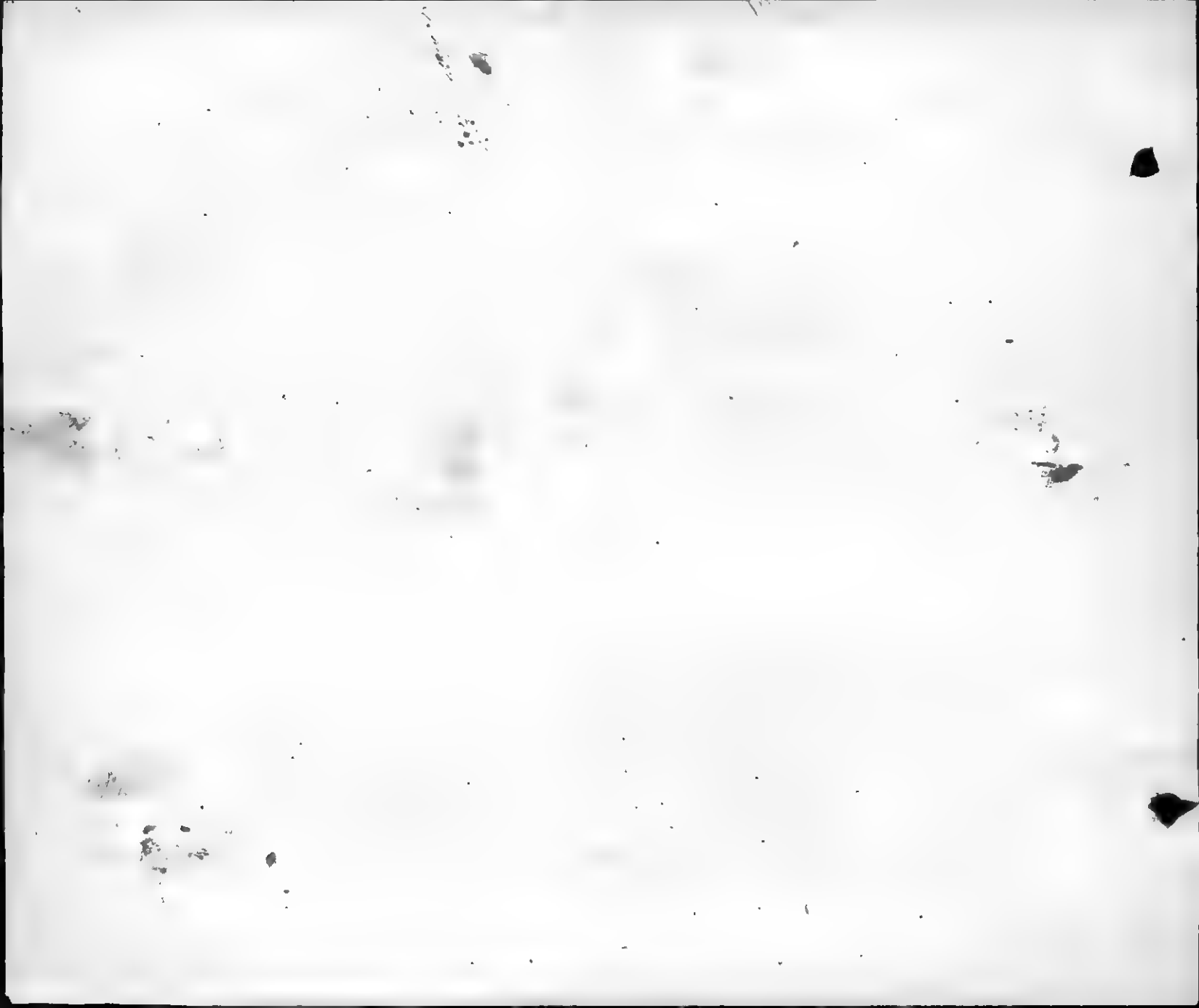
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>2 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PARADISE NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>J</u> Middle <u>CLARET</u> Last <u>FRANCIS</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>21</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 23, 1880</u>
9. AGE (In years last birthday) <u>79 yrs.</u>		10. UNDER 1 YEAR Months <u>7</u> Days <u>21</u> Hours <u>0</u> Min <u>0</u>	11. UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SCHOOL TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BALTO. MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES ALBERT FRANCIS</u>		14. MOTHER'S MAIDEN NAME <u>EMMA V HENRY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-24-4760</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>151X Carcinoma of the Stomach with Metastases.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>with Metastases.</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/21/60</u> 19 <u>60</u> to <u>2/21/60</u> , that I last saw the deceased alive on <u>2/20/60</u> 19 <u>60</u> and that death occurred <u>835A M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. E. McGreth</u>		DATE SIGNED <u>2/22/60</u>	
PHYSICIAN'S NAME (Type) <u>W. E. McGreth</u>		ADDRESS (Street, city or town, state) <u>1308 Frederick Rd Catonsville 28nd</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/24/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN CEM</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. ...</u>		24. REC'D BY REGISTRAR DATE <u>FEB 24 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Clara S. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1636

Item 9 File 6250 2-23-60 et  
 CERTIFICATE OF DEATH

01618

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RT. 15, Box 175</b>		c. LENGTH OF STAY IN 1b <b>8 MOS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>74 BALTIMORE 20, MD.</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1 RT-15, Box 175</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>R</b> Last <b>FRYE SR.</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>16</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 25-1866</b>
9. AGE (In years last birthday) <b>93 1/4</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
INFORMANT <b>MEDICAL RECORDS</b> Address <b>805 Fuseclage Ave. BALTIMORE 20, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROSIS, Generalized</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 days.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>OLD FRACTURED HIP</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>AUGUST 15, 1959</b> to <b>FEB 16, 1960</b> , that I last saw the deceased alive on <b>FEB 15, 1960</b> , and that death occurred at <b>9:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>M. A. Castro, Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>805 FUSECLAGE AVE</b> DATE SIGNED <b>2/17/60</b>	
PHYSICIAN'S NAME (Type) <b>M. A. CASTRO, JR. M.D.</b>		<b>BALTIMORE 20, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>2-17-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>WINNDALE</b>		22d. LOCATION (City, town, or county) (State) <b>PITTSBURG, PENNSYLVANIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Connolly</b> ADDRESS <b>418 Eastern Blvd.</b>		24a. REC'D BY REGISTRAR <b>FEB 18 '60</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>Charles E. Hanna</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 6257 2-6-60 et

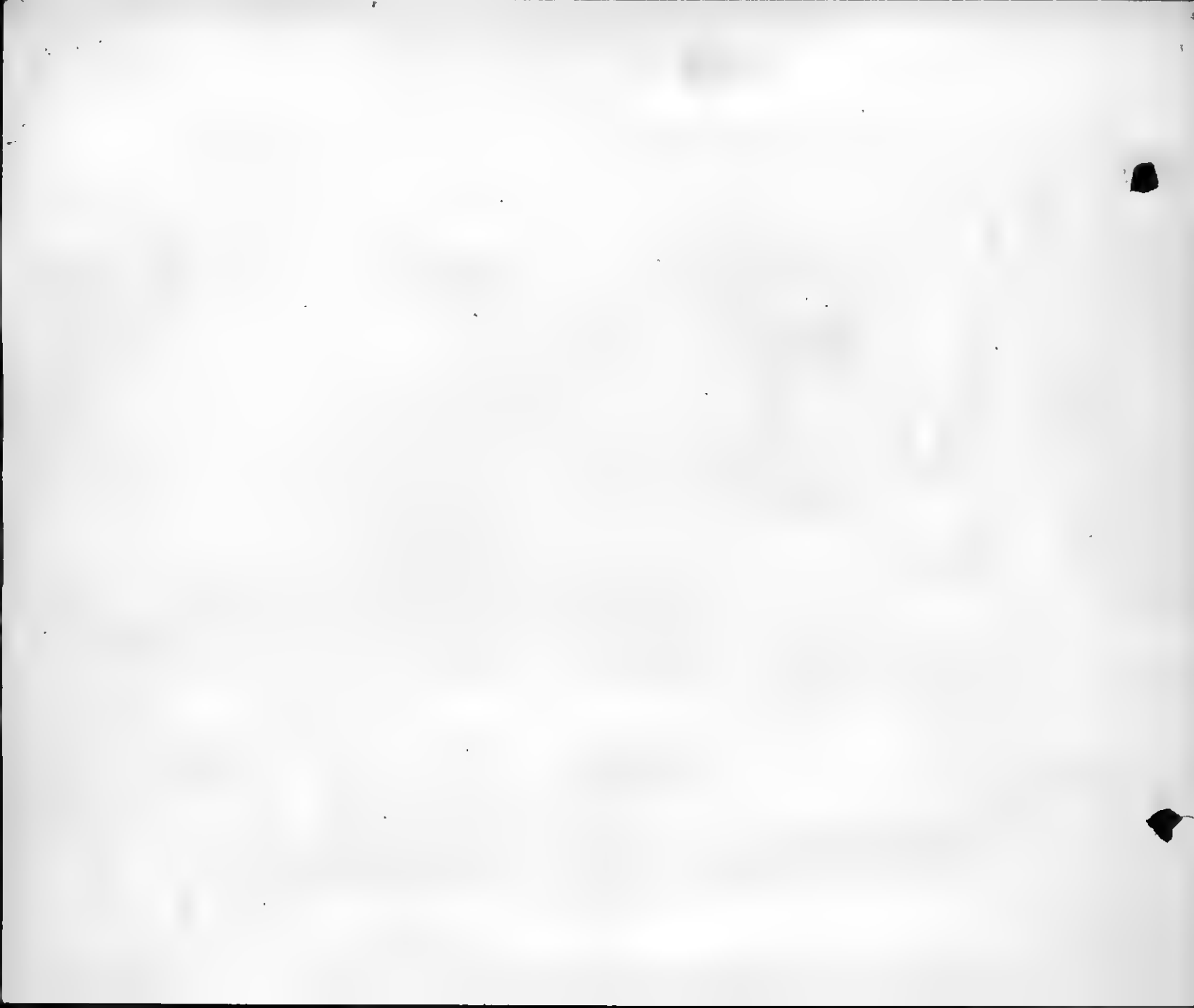
## 1566 CERTIFICATE OF DEATH

Reg. Dist. No.

01619

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DELLA</b> c. LENGTH OF STAY IN 1b <b>25 yrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>336 DELLA AVE</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X DELLA</b> d. STREET ADDRESS <b>336 DELLA AVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LLOYD THOMAS GAITHER</b> First Middle Last		4. DATE OF DEATH Month <b>2</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/5/1891</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min.	11. IF UNDER 24 HRS Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER-RETIRED POULTRY FARM</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOWARD CO. MD</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LLOYD T. GAITHER</b>		14. MOTHER'S MAIDEN NAME <b>FLORENCE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>ROSIE LEE GAITHER</b> Address <b>DELLA - MD.</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, rectum</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>154X</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>18 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7-2</b> , 19 <b>59</b> , to <b>2-24</b> , 19 <b>60</b> that I last saw the deceased alive on <b>2-9</b> , 19 <b>60</b> , and that death occurred at <b>1:30</b> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas F. Herbert</b> M.D.		ADDRESS (Street, city or town, state) <b>46 Church Rd</b> DATE SIGNED <b>2-22-60</b>	
PHYSICIAN'S NAME (Type) <b>Thomas F. Herbert, M.D.</b>		<b>Ellicott City, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>2/24/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>White Rock</b>	22d. LOCATION (City, town, or county) (State) <b>Carroll Co. - Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Massieu Hays 638 n. g. hwy 66</b> ADDRESS <b>Baltimore</b>		24a. REC'D BY REGISTRAR <b>FEB 23 '60</b>	24b. REGISTRAR'S SIGNATURE <b>J. L. H. H. H.</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



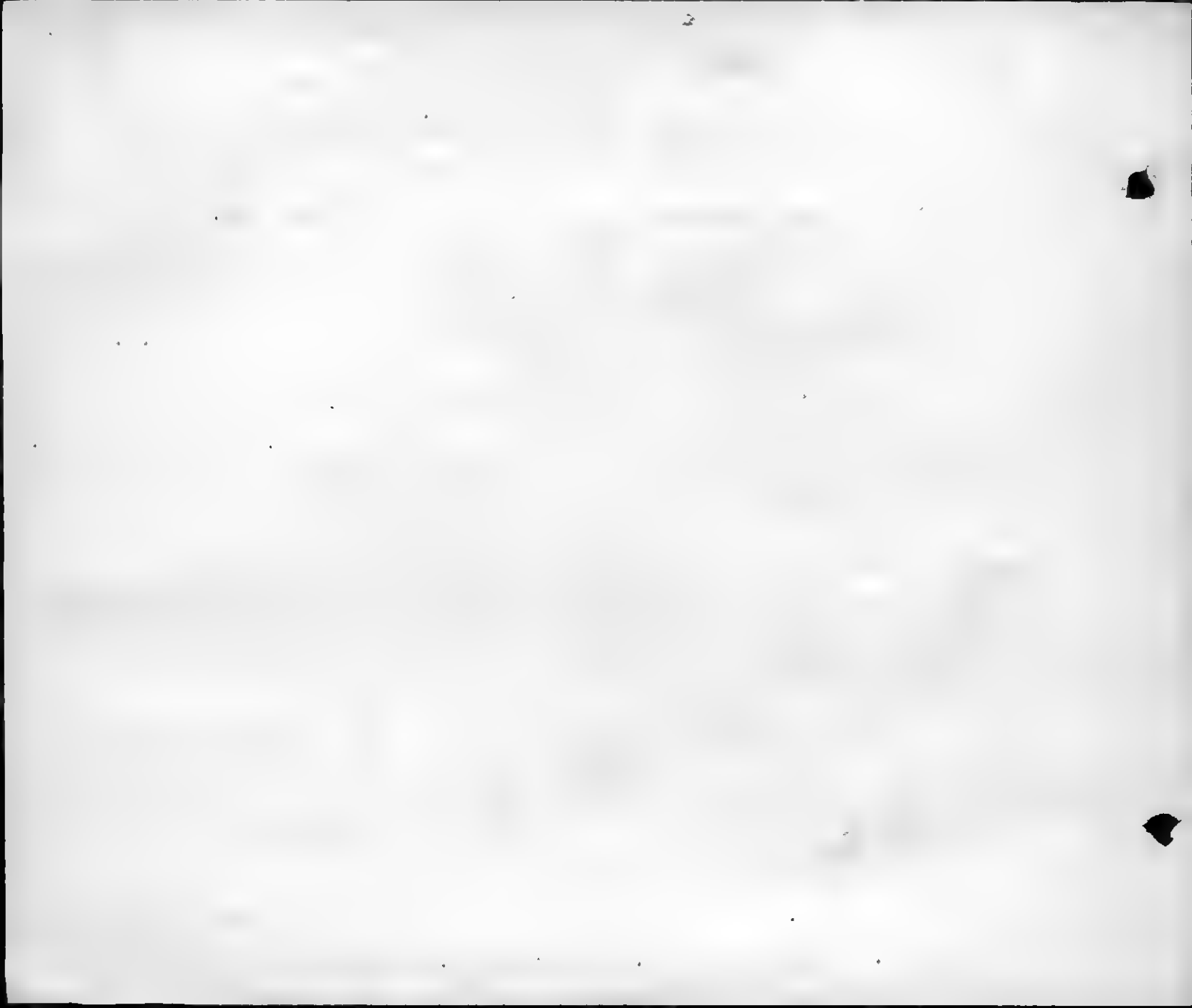
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1637

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01620

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Convalescent Home</b>				d. STREET ADDRESS <b>552 Alleghany Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>India</b> Last <b>Gammie</b>				4. DATE OF DEATH Month <b>2</b> Day <b>7</b> Year <b>1960</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-4-1873</b>		9. AGE (In years last birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months <b>8</b> Days <b>7</b> Hours <b>19</b> Min.	IF UNDER 24 HRS Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Clary</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Donaldson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Donald Gammie (son)</b> Address <b>552 Alleghany Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular disease</b> <b>422.1</b> DUE TO <b>pneumonitis</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO <b>—</b> (c) <b>—</b>						INTERVAL BETWEEN ONSET AND DEATH <b>about 1 yr 10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>—</b> p. m. <b>—</b> 19 <b>60</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 29</b> 19 <b>60</b> , to <b>Feb 8</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Feb 6</b> 19 <b>60</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Walter S. Tublett</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Walter S. Tublett</b>				22d. ADDRESS <b>1501 Pentridge Rd.</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 10, 60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Jenkins Sons Co.</b>				25a. REC'D BY REGISTRAR <b>4905 York Rd.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>	

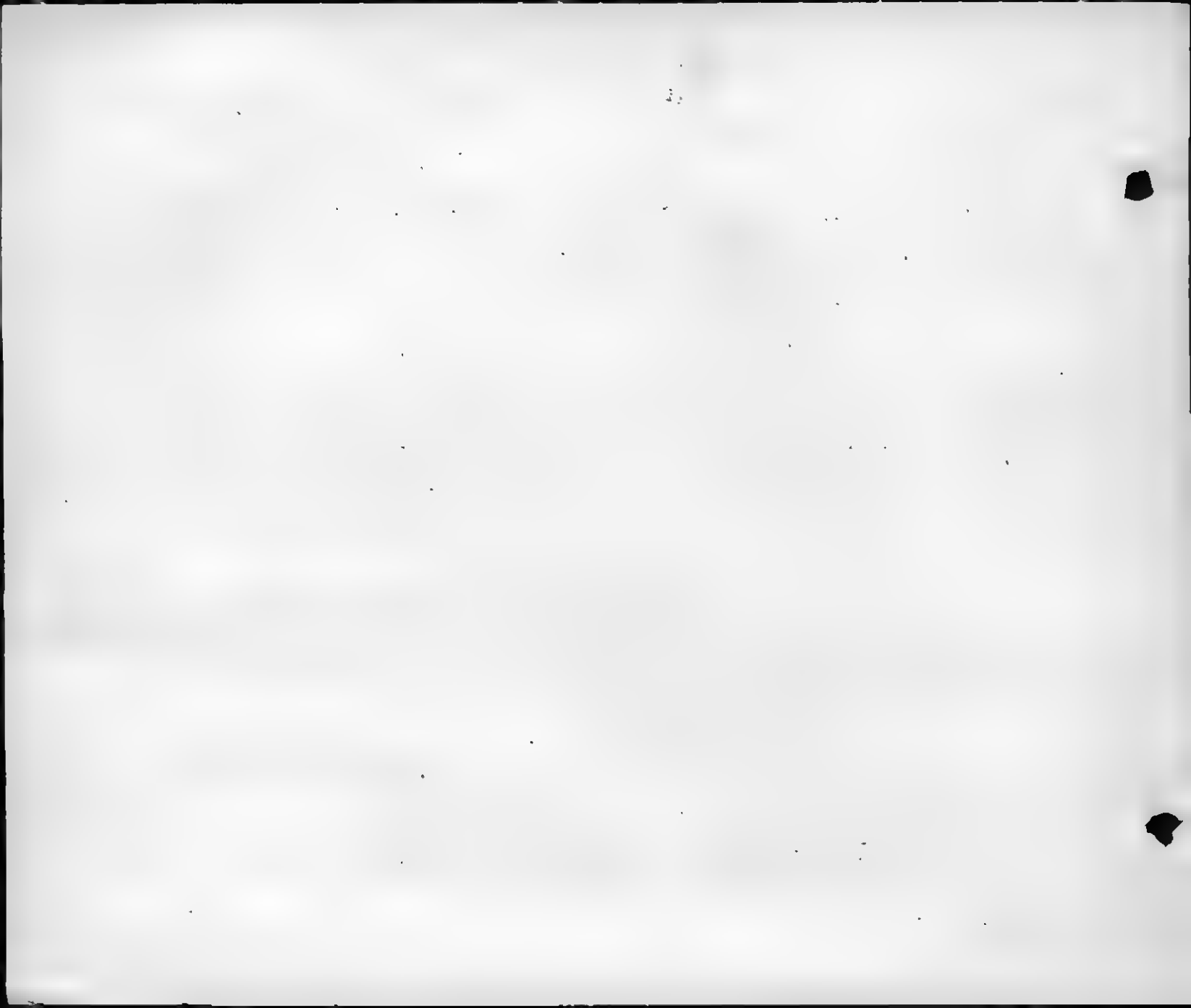


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1638 CERTIFICATE OF DEATH

01621

1 PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Calonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>118 Smithwood Ave.</u>		d. STREET ADDRESS <u>118 Smithwood Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>George S. Gardner</u>		4. DATE OF DEATH <u>Feb 11 1960</u>	
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/7/92</u>
9. AGE (In years last birthday) <u>67</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ret.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard T. Gardner</u>		14. MOTHER'S MAIDEN NAME <u>Freeman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes WWI</u>		16. SOCIAL SECURITY NO. <u>Nettie Carter</u>	
17. INFORMANT <u>Nettie Carter</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>454.0</u> DUE TO <u>Congestive heart failure (right)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cor-pulmonale</u> (c) <u>Cor-pulmonale</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Feb. 8 1960</u> to <u>Feb. 11 1960</u> that (I) (we) last saw the deceased alive on <u>Feb. 11 1960</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>R.M. Henning</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>R.M. HENNING</u>		22d. ADDRESS <u>203-Ingleside Ave. Balto. 28</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
<u>Burial</u>		<u>2/15/60</u>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>U.S. National</u>		<u>Balto. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. Webb &amp; Son</u>		ADDRESS <u>28</u>	
25a. REC'D BY REGISTRAR DATE <u>FEB 16 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	





TO DEPUTY MEDICAL EXAMINER: This certificate must be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director to be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 01622									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN 1b <b>7yr8mth23dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Abell, Maryland</b>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>					d. STREET ADDRESS <b>---</b>				
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Edward</b> Last <b>Gass</b>					4. DATE OF DEATH Month <b>February</b> Day <b>15</b> Year <b>1960</b>				
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 17, 1880</b>		9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>sailor and farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>George W. Gass</b>					14. MOTHER'S MAIDEN NAME <b>Julia Harden</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>unknown</b>			16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Terminal Pneumonia</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio vascular disease</b> DUE TO <b>Fracture left femur intertrochanteric</b> (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>On 1-21-60 pt. was pushed down by another patient while walking to the porch sustaining an comminuted intertrochanteric fracture of left femur.</b>						
20c. TIME OF INJURY Hour <b>10:20</b> a. m. Month, Day, Year <b>1-21-60</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>hospital</b>		20f. (City or town) <b>Catonsville 28, Maryland</b>		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>George M. Kieffer</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DATE SIGNED <b>2-16-60</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/19/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>		22d. LOCATION (City, town, or county) (State) <b>Greenwood, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. E. Hartman</b>				ADDRESS <b>Greenwood</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 24 '60</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Harris</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 6257 3-1-60 et

## CERTIFICATE OF DEATH

01623

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
c. LENGTH OF STAY (In 1b) <b>2 yrs. 10 mths</b>				d. STREET ADDRESS <b>104 W. University Parkway</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>College Manor Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Amelia</b> Middle <b>Gildea</b> Last <b>Gildea</b>				4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>1960</b>			
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Jan. 21, 1876</b>	9. AGE (In years last birthday) <b>84</b> yrs	IF UNDER 1 YEAR Months <b>3</b> Days <b>20</b> Hours <b>14</b> Min	IF UNDER 24 HRS Hours <b>14</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>John Sauer</b>			
14. MOTHER'S MAIDEN NAME <b>Margaret Romosher</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO				17. INFORMANT <b>William P. Gildea, Jr., 618 Meadow Ridge Rd</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardio-Vascular Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>5 yrs</b>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>January 10, 1950</b> to <b>February 20, 1960</b> , that I lost the deceased alive on <b>February 19, 1960</b> , and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Philip D. Flynn</b>				ADDRESS (Street, city or town, state) <b>11 E. Chase St. Baltimore - 2 Md.</b>			
DATE SIGNED <b>2/29/60</b>				PHYSICIAN'S NAME (Type) <b>Philip D. Flynn, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-23-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Towson, Inc., 1050 York Road, Towson</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 25 '60</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>							

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1641

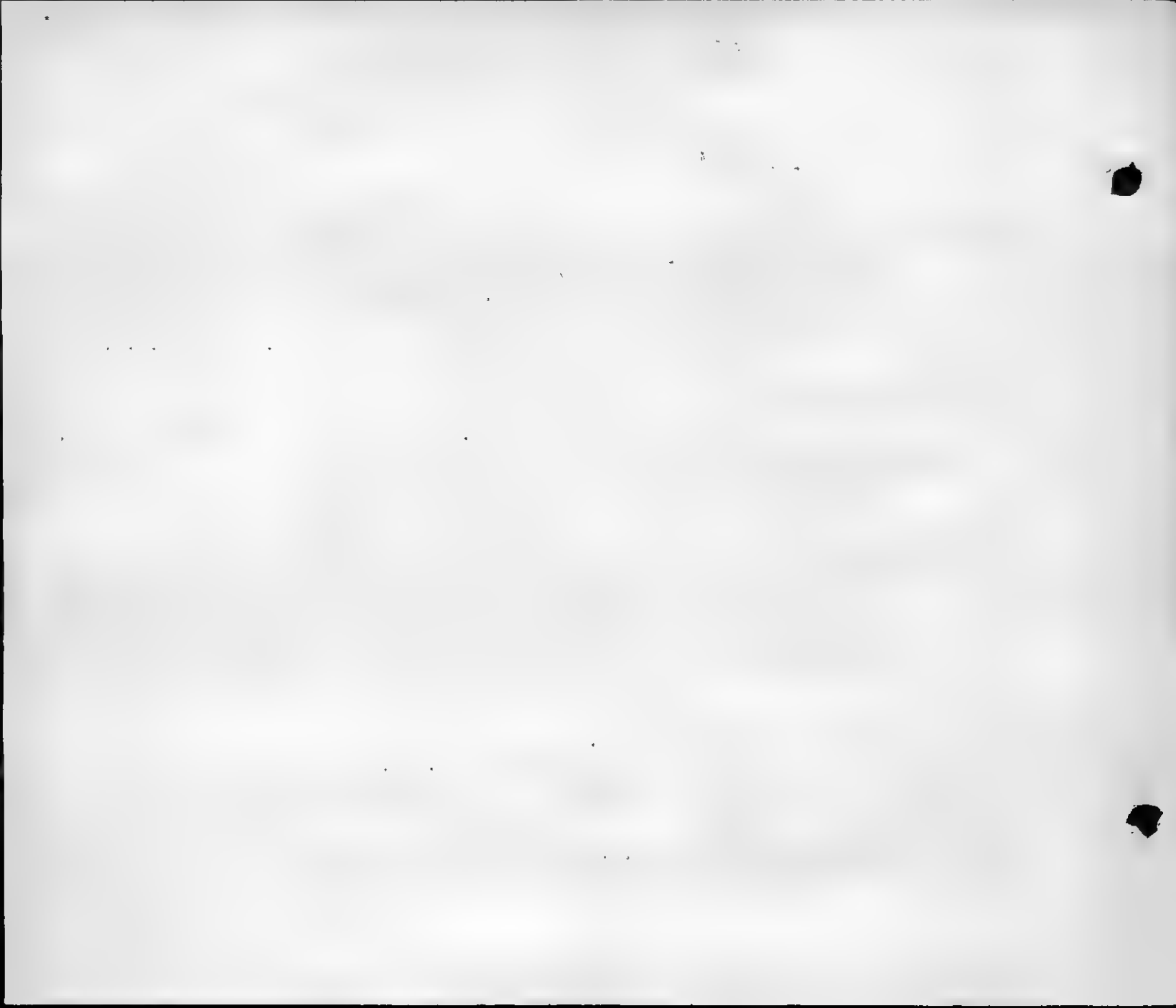
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Towson</u>				c. LENGTH OF STAY IN 1b X <u>Rural Towson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Elonora Road</u>				d. STREET ADDRESS <u>Elonora Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sister Mary M. Green Gormley</u>				4. DATE OF DEATH Month Day Year <u>February 16 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1891</u>		9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>		11. BIRTHPLACE (State or foreign country) <u>Jessica Plain, Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Gormley</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Mc Dermott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Sister M. Peter Fourier</u>		Address <u>Notch Cliff, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>							
442X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
(b) <u>Hypertensive cardio-renal vascular disease</u>							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan. 21</u> 19 <u>60</u> , to <u>Feb. 16</u> 19 <u>60</u> , that I last saw the deceased alive on <u>Feb. 16</u> 19 <u>60</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.				ADDRESS (Street, city or town, state) <u>701 York Rd. Towson 4, Md.</u>			
DATE SIGNED <u>2/23/60</u>							
PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-22-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SISTERS' CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO.</u> <u>N. CHARLES ST. &amp; HOMELAND AVES. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Giller</u>				ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 23 60</u>	
				24b. REGISTRAR'S SIGNATURE <u>William S. Kneale</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1642

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01625

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Timonium</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6 Washington Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Francis Griffin</u>				4. DATE OF DEATH Month Day Year <u>Feb. 14 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1897</u>	9. AGE (In years last birthday) <u>62</u> yrs	IF UNDER 1 YR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Connecticut</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George F. Griffin</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Mihill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO <u>1</u>		17. INFORMANT Address <u>Mrs. Helen Dewees Griffin above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute CORONARY Occlusion - 420.1</u> DUE TO (b) <u>Mild Hypertension -</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-24-1959</u> to <u>2-14-1960</u> , that (I) (we) last saw the deceased alive on <u>1-23-1960</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Anthony F. Carozza</u> M D				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYS CIAN'S NAME (Type) <u>Anthony F. CAROZZA</u>				22d. ADDRESS <u>5217 YORK Rd BALT. 12 Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-17-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H. J. Jenkins &amp; Sons Co. 40.5 York Rd.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 17 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	





CERTIFICATE OF DEATH

01526

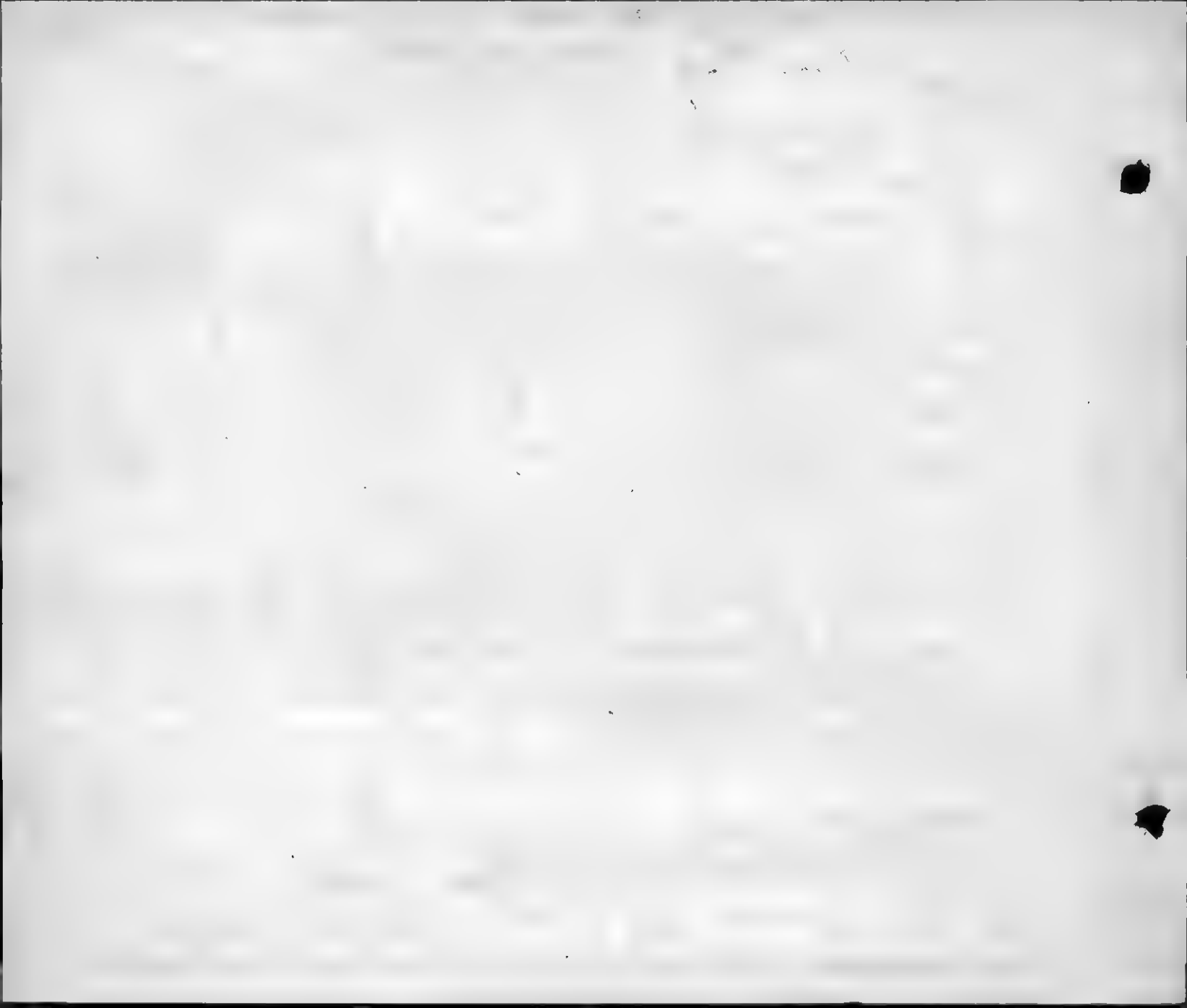
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Windsor Mill Rd Ext</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>13 Alto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 ALTO COUNTY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>7 Month X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Windsor Mill Rd Ext</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EMMA PAULINE GUIBERINATIS</u>		4. DATE OF DEATH <u>2</u> Month <u>27</u> Day <u>79</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 2 1819</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>13 ALTO MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHRISTIAN CAKENHEIMER</u>		14. MOTHER'S MAIDEN NAME <u>CHARLOTTA HICKEL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS SIENNIE ECKER WINDS</u>		Address <u>SUB MIL RD EXT</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMA - BREAST</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>METASTASIS TO LUNG</u> DUE TO (c) <u>GENERALIZED CARCINOMATOSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 years / 1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>DEC 16</u> , 1959, to <u>FEB 27</u> , 1960, that I last saw the deceased alive on <u>FEB 27</u> , 1960, and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas E. Wheeler</u>		ADDRESS (Street, city or town, State) <u>Randallstown - Md -</u> DATE SIGNED <u>2/27/60</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>MAR 2</u>	<u>LOUGHRAN CEMETERY</u>	<u>FREDERICK AVE</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>GEORGE LEIMBACH 5227 LYNDA HURST ST</u>		24a. REC'D BY REGISTRAR <u>MAR 1 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

MEDICAL CERTIFICATION

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



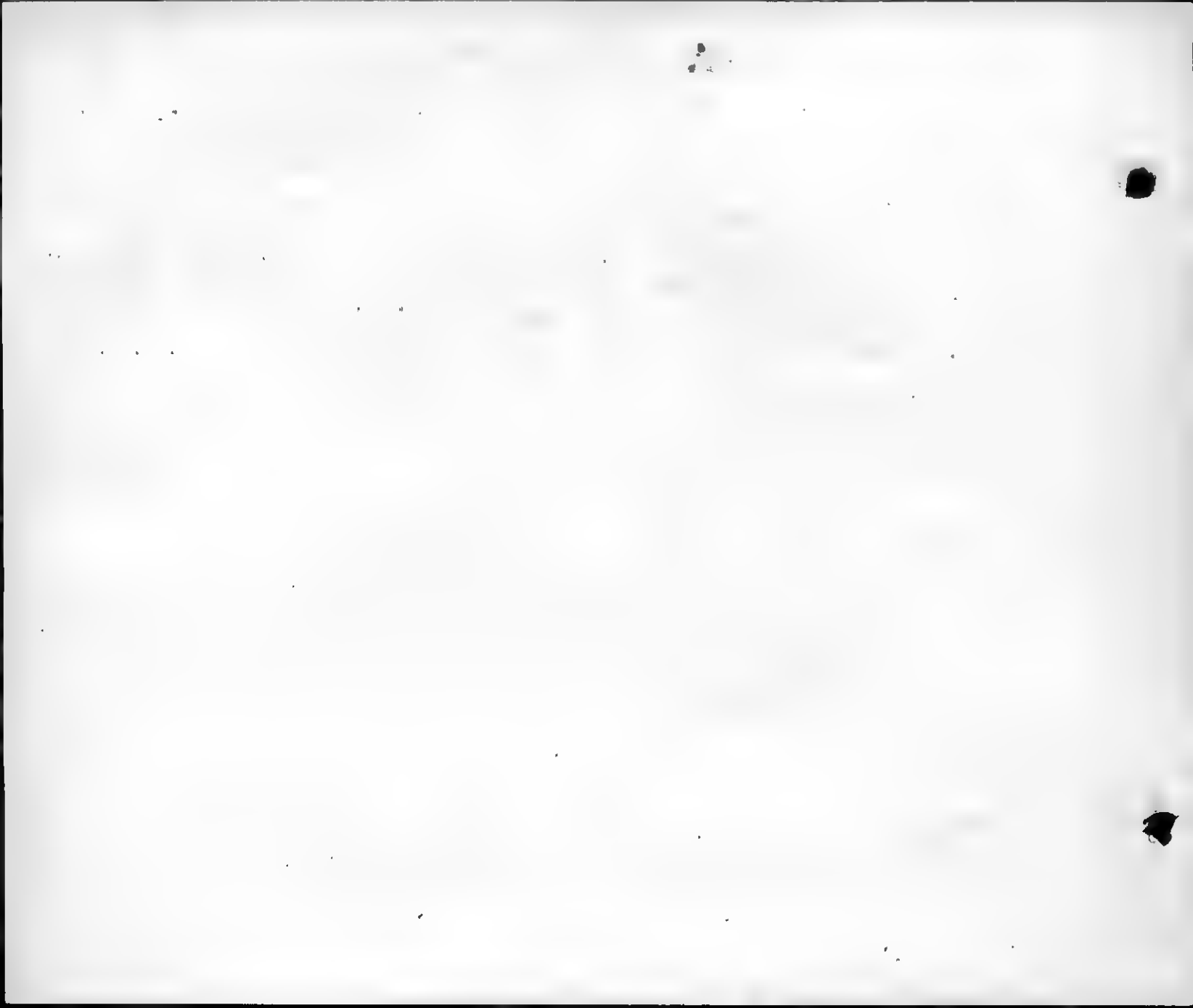
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1644 CERTIFICATE OF DEATH

Reg. Dist. No.

01627

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>16 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Phillip</b> Middle <b>S.</b> Last <b>Harbaugh</b>				4. DATE OF DEATH Month <b>February</b> Day <b>13</b> Year <b>1960</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1884 Jan. 8,</b>	
9. AGE (In years last birth day) <b>76 yrs.</b>		10. IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>Charles Harbaugh</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>			
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Cardiac failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Age. C. v. Disease</b> (c) <b>Arteriosclerosis general, severe</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Feb. 5, 1960</b> to <b>February 13, 1960</b> , that I last saw the deceased alive on <b>February 13, 1960</b> , and that death occurred at <b>3 A.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D.				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>2/13/60</b>			
PHYSICIAN'S NAME (Type) <b>STELLA WACHSLER</b>				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, or other disposition (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Feb. 15, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FAIRFIELD UNION CEMETARY</b>		22d. LOCATION (City, town, or county) (State) <b>FAIRFIELD PA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Wilson (P.G.W.)</b>				24a. REC'D BY REGISTRAR <b>FAIRFIELD, PA.</b>		24b. REGISTRAR'S SIGNATURE <b>Feb 16 '60</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

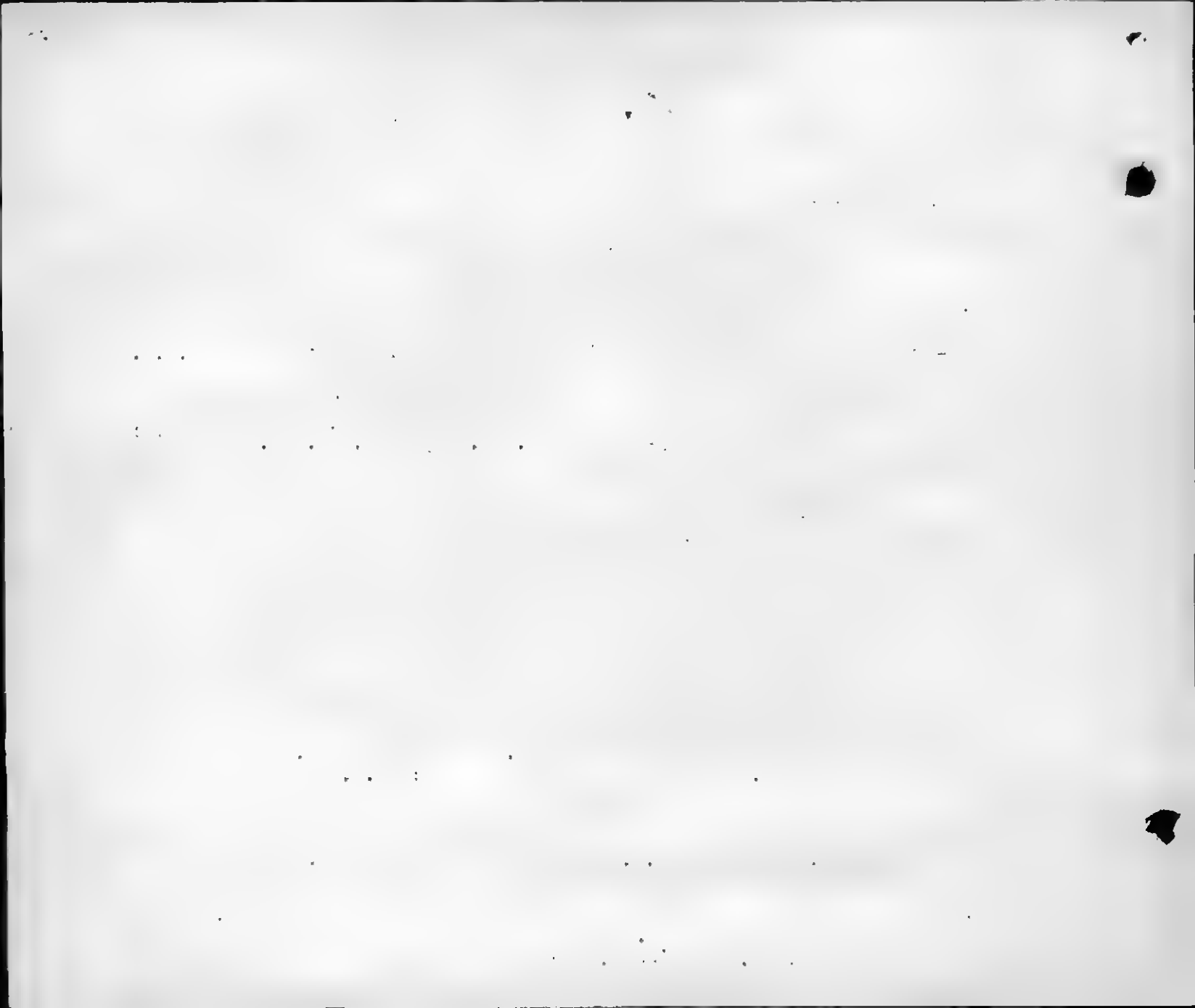
**1643 CERTIFICATE OF DEATH**

01628

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>1 Day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>(NMI)</b> Last <b>HARRIS</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>14</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/23/88</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Oilier-Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Merchant Marines</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Harris</b>				14. MOTHER'S MAIDEN NAME <b>Sadie Pentz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>WW I 222-03-8844</b>		17. INFORMANT <b>BENJAMIN F. HARRIS</b>			<b>124 S. HAVEN ST. Clin. Rec. VAH, Balto. Md. Ft. Howard Division</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> <b>473X</b> <b>XX</b> <b>CARCINOMA OF BLADDER</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>  <b>2 MONTHS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>XX</b> (this hospital) attended the deceased from <b>Feb. 12</b> <b>1960</b> to <b>Feb. 14</b> <b>1960</b> , that <b>XX</b> (we) last saw the deceased alive on <b>Feb. 14</b> <b>1960</b> , and that death occurred at <b>1:38 A.M.</b> on the causes and on the date stated above.							
22a. SIGNATURE <i>John E. Eisenlohr</i>				22b. DATE SIGNED <b>2/14/60</b>		22c. PHYSICIAN'S NAME (Type) <b>JOHN E. EISENLOHR, M.D.</b>	
22d. ADDRESS <b>VAH, BALTIMORE, MD. FORT HOWARD DIVISION</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/17/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry Sander &amp; Sons, Inc.</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 16 '60</b>		25b. REGISTRAR'S SIGNATURE <i>Anthony E. K...</i>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

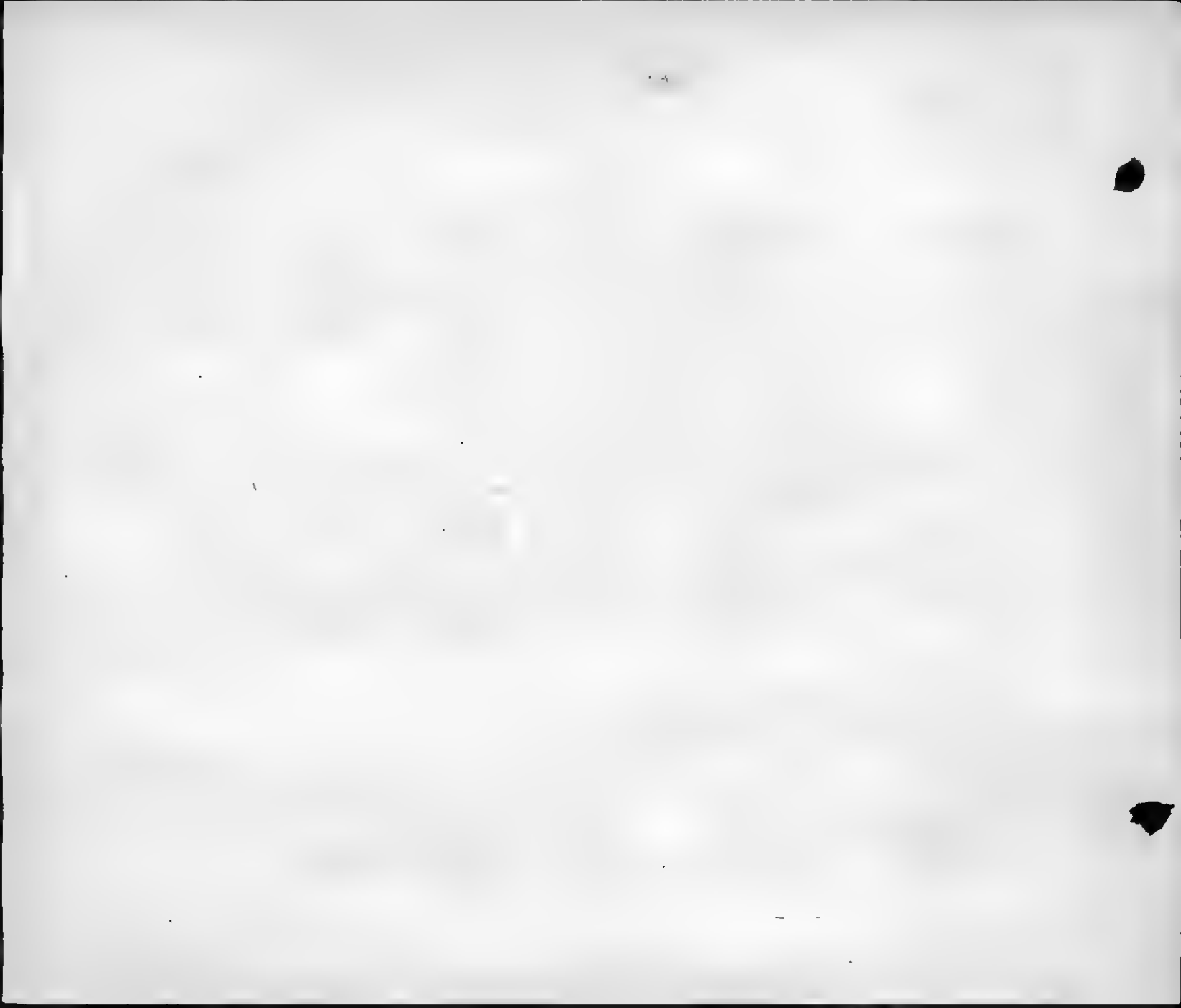
01629

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN <u>Balto</u> , <u>MD</u>		c. CITY OR TOWN <u>Baltimore</u> , <u>MD</u>	
c. LENGTH OF STAY IN 1b <u>4 yr</u>		d. STREET ADDRESS <u>12618 Matthews Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2618 Matthews Drive</u>			
3. NAME OF DECEASED (Type or print) <u>ALLEN WATSON HEATH</u>		4. DATE OF DEATH <u>4-14</u> Month <u>4</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 20 1907</u>
9. AGE (in years not birthday) <u>52 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Earl Heath</u>		14. MOTHER'S MAIDEN NAME <u>Isabel Stacey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Full time</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Wife</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>330X</u> DUE TO <u>Subarachnoid hemorrhage</u>			
(b) <u>Repeated Thrombotic Emboli</u>			
(c) <u>massive thrombus</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1954</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank T. Kasir Jr.</u>		DATE SIGNED <u>2/14/60</u>	
EXAMINER'S NAME (Type) <u>FRANK T KASIR JR.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2-17-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 18 '60</u>	
ADDRESS <u>5305 Harford Rd</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1043. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 1647 CERTIFICATE OF DEATH

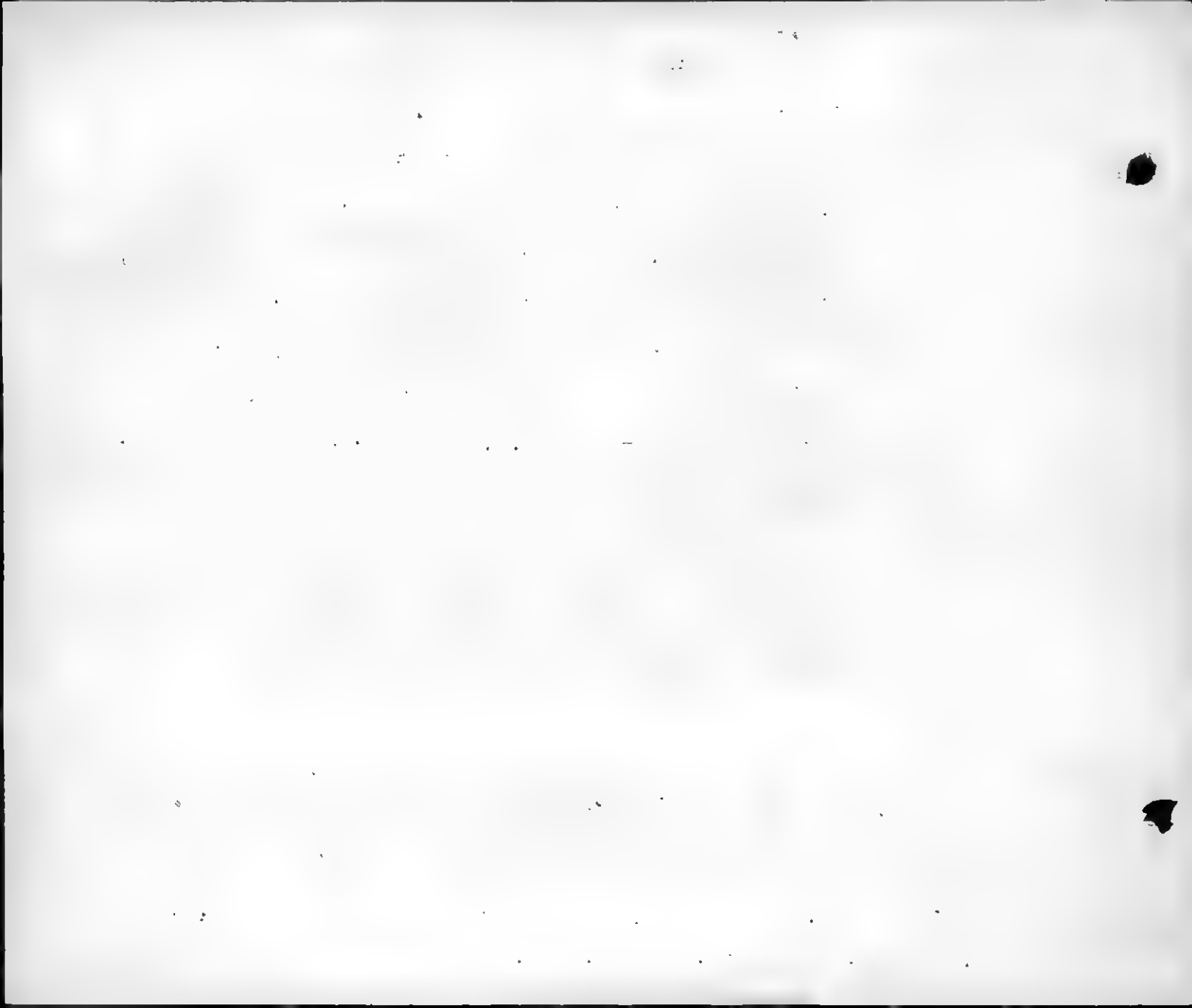
Reg. Dist. No.

01630

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore-Parkville - 14</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7801 Ardmore Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>M.</b> Last <b>HEINBUCH</b>		4. DATE OF DEATH Month <b>February</b> Day <b>7</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 2, 1878</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>81</b> Days <b>81</b> Hours <b>81</b> Min.	11. IF UNDER 24 HRS Months <b>81</b> Days <b>81</b> Hours <b>81</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Adam Miller</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Reese</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-12-7892</b>	
17. INFORMANT <b>Mr. N. Hilton Heinbuch-295 Cold Spring Rd</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>2040</b> DUE TO <b>Bronchial infection</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2 yrs</b> (c) <b>5 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b> <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1945</b> to <b>2/7/60</b> , that I last saw the deceased alive on <b>2/5/60</b> , 19 <b>19</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>4331 Harford Rd</b> DATE SIGNED	
ACTUAL SIGNATURE <b>Walter E. Harford</b> M.D.		PHYSICIAN'S NAME (Type) <b>Walter E. Harford</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 11, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. SANDER &amp; SONS, INC.</b>		24a. REC'D BY REGISTRAR <b>Balto., Md.</b>	
24b. REGISTRAR'S SIGNATURE <b>Feb 10 '60</b>		24c. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1648

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

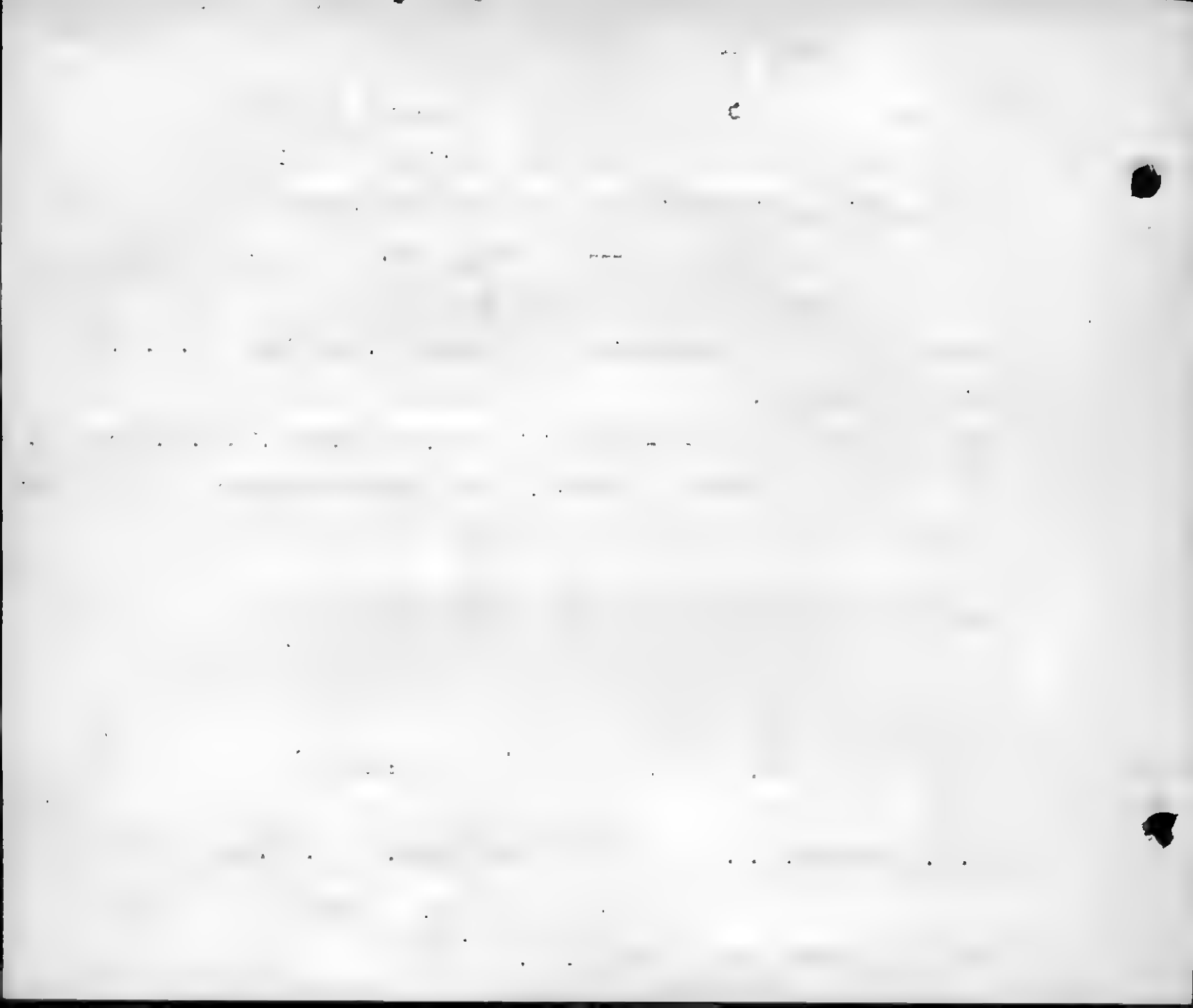
CERTIFICATE OF DEATH

01631

Item 23b, Form 6230-11/60

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>56 Days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>(K)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>605 Brune Street</b>					
3. NAME OF DECEASED (Type or print) First <b>OLIVER</b> Middle <b>---</b> Last <b>HENDERSON, JR.</b>		4. DATE OF DEATH Month <b>February</b> Day <b>9</b> Year <b>19 60</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 22, 1929</b>	9. AGE (In years lost birthday) <b>30</b> yrs	IF UNDER 1 YEAR Months <b>3</b>	IF UNDER 24 HRS Days <b>1</b> Hours <b>4</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Gastonia, N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Oliver Henderson, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Ada Neely</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>211-26-0876</b>		17. INFORMANT <b>Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>OSTEOGENIC SARCOMA, RIGHT ILEUM WITH METASTASES</b> <b>196.6</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>---</b> DUE TO (c) <b>---</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 MONTHS</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Operation Curettage and Drainage, Right Ileum 12/18/60</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>W</b> (this hospital) attended the deceased from <b>Dec. 15</b> <b>19 59</b> to <b>Feb. 9</b> <b>19 60</b> that <b>W</b> (we) last saw the deceased alive on <b>Feb. 9</b> <b>19 60</b> , and that death occurred at <b>10:32PM</b> on the causes and on the date stated above.							
22a. SIGNATURE <b>W. J. Pijanowski</b>		M. D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2/10/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. J. PIJANOWSKI, M.D.</b>		22d. ADDRESS <b>VAH, BALTO. 18 MD. FT. HOWARD DIVISION</b>					
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 15, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy Wilson</b>		ADDRESS <b>1000 Brantley Ave.</b>		25a. REC'D BY REGISTRAR <b>FEB 24 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Christina S. Kline</b>	

Elroy Wilson Funeral Home, 5301 Balto. Md.



1649

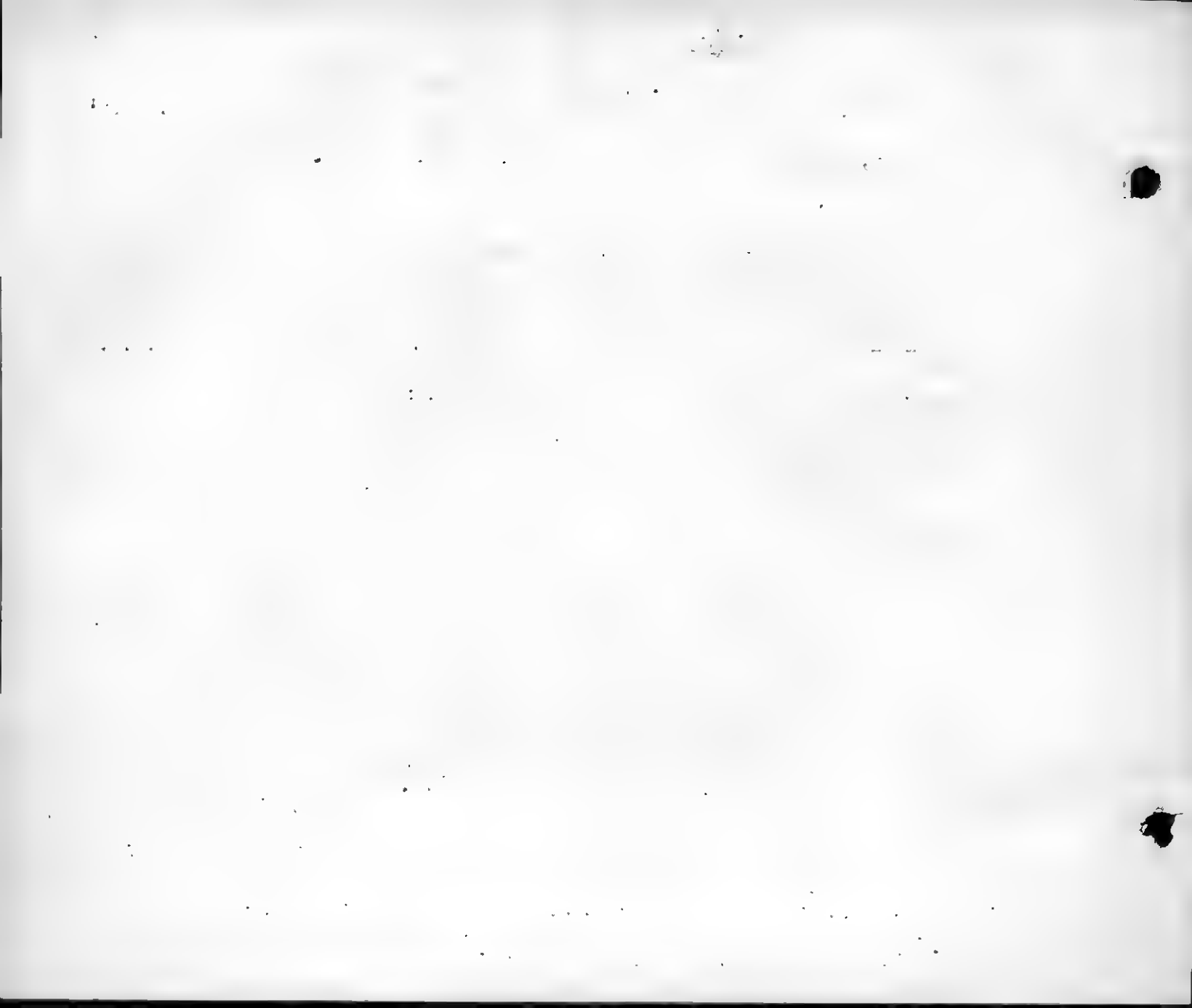
CERTIFICATE OF DEATH

Reg. Dist. No.

01632

1. PLACE OF DEATH <u>Rosewood State Training School</u> a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>				c. LENGTH OF STAY IN 1b <u>15 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Preston</u> Middle <u>Ignatius</u> Last <u>Hewitt</u>				4. DATE OF DEATH Month <u>2</u> Day <u>3</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/5/32</u>	
9. AGE (In years last birthday) <u>27</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Irving Hewitt</u>				14. MOTHER'S MAIDEN NAME <u>Edith Combs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Rosewood Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Grand mal seizure in status epilepticus</u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o m <u>  </u> p. m <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>  </u> , 19 <u>  </u> , to <u>  </u> , 19 <u>  </u> , that I last saw the deceased alive on <u>  </u> , 19 <u>  </u> , and that death occurred at <u>11:30M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P. W. Rieckert</u>				ADDRESS (Street, city or town, state) <u>4307 Mainfield Rd Baltimore 14 Md</u>			
PHYSICIAN'S NAME (Type) <u>P. W. Rieckert</u>				DATE SIGNED <u>2/3/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>2/6/60</u>		<u>Holy Tree</u>		<u>Owings Mills Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. W. Rieckert</u>				ADDRESS <u>  </u>		24a. REC'D BY REGISTRAR <u>FEB 8 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1650

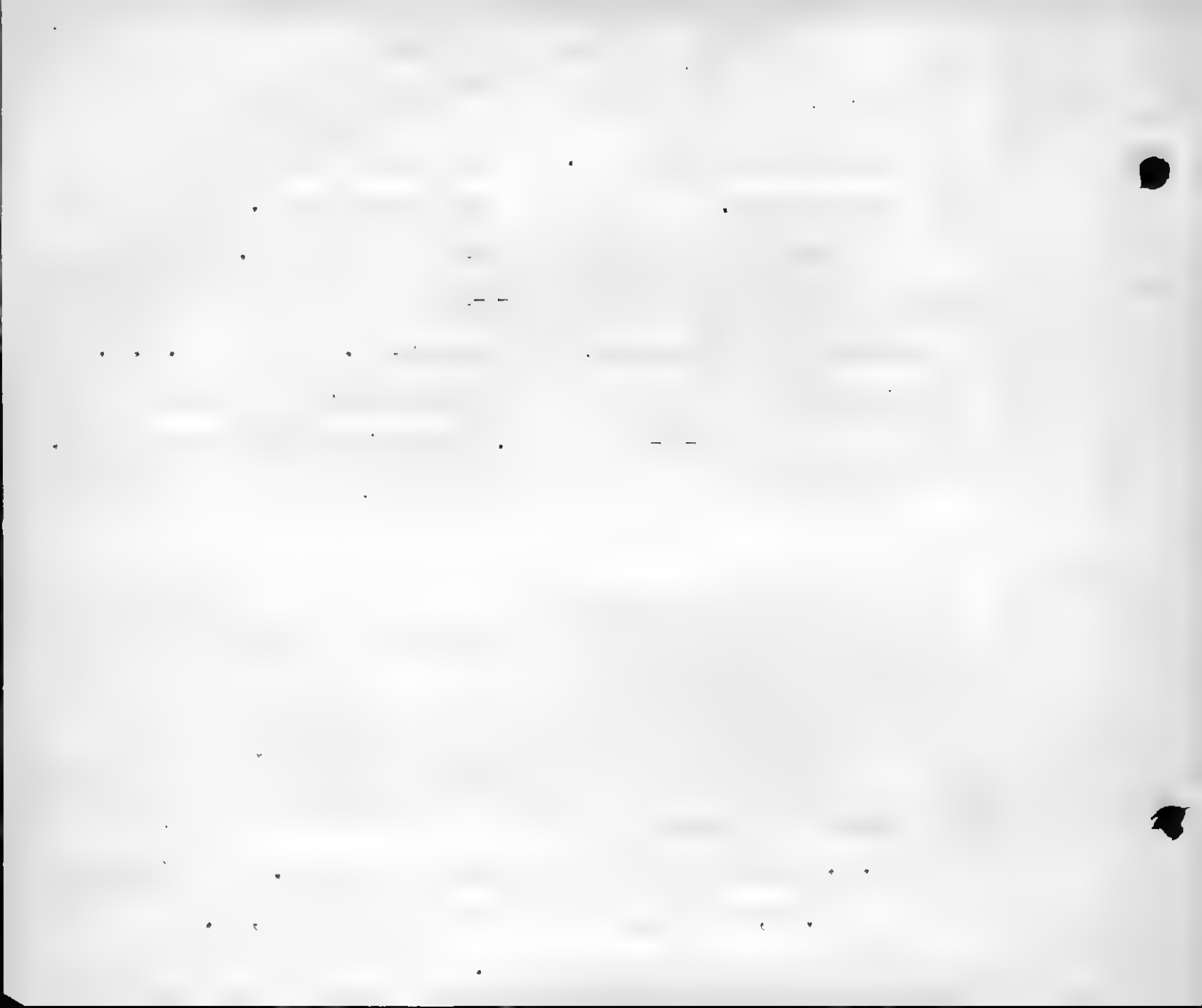
## CERTIFICATE OF DEATH

01633

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baynesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baynesville</b>			
c. LENGTH OF STAY IN 1b <b>about 1 yr.</b>				d. STREET ADDRESS <b>8611 Chestnut Oak Rd.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8611 Chestnut Oak Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Catherine</b> Middle <b>Louise</b> Last <b>Hild</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>14</b> Year <b>1960</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-3-1903</b>	9. AGE (In years last birthday) <b>56</b> yrs	IF UNDER 1 YEAR Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>saleslady</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dry Cleaning</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Valentine Staab</b>			14. MOTHER'S MAIDEN NAME <b>Mary Fatcher</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-28-3162</b>		17. INFORMANT <b>Mrs. Frances Cicero</b> Address <b>8611 Chestnut Oak Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary artery thrombosis</b> <b>420.1</b> DUE TO (b) <b>Angina pectoris</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/1/60</b> , 19 <b>60</b> , to <b>2/14</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>2/14</b> , 19 <b>60</b> , and that death occurred at <b>5A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Gordon Grau</b> M.D.				ADDRESS (Street, city or town, state) <b>8523 Lock Raven Rd.</b> DATE SIGNED <b>2/15/60</b>			
PHYSICIAN'S NAME (Type) <b>Dr. E. Gordon Grau</b>				ADDRESS <b>8523 Lock Raven Rd.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 17, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Vernon L. Lamm</b> ADDRESS <b>4611 Park Heights Ave.</b>				24a. REC'D BY REGISTRAR <b>FEB 18 1960</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Charles E. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

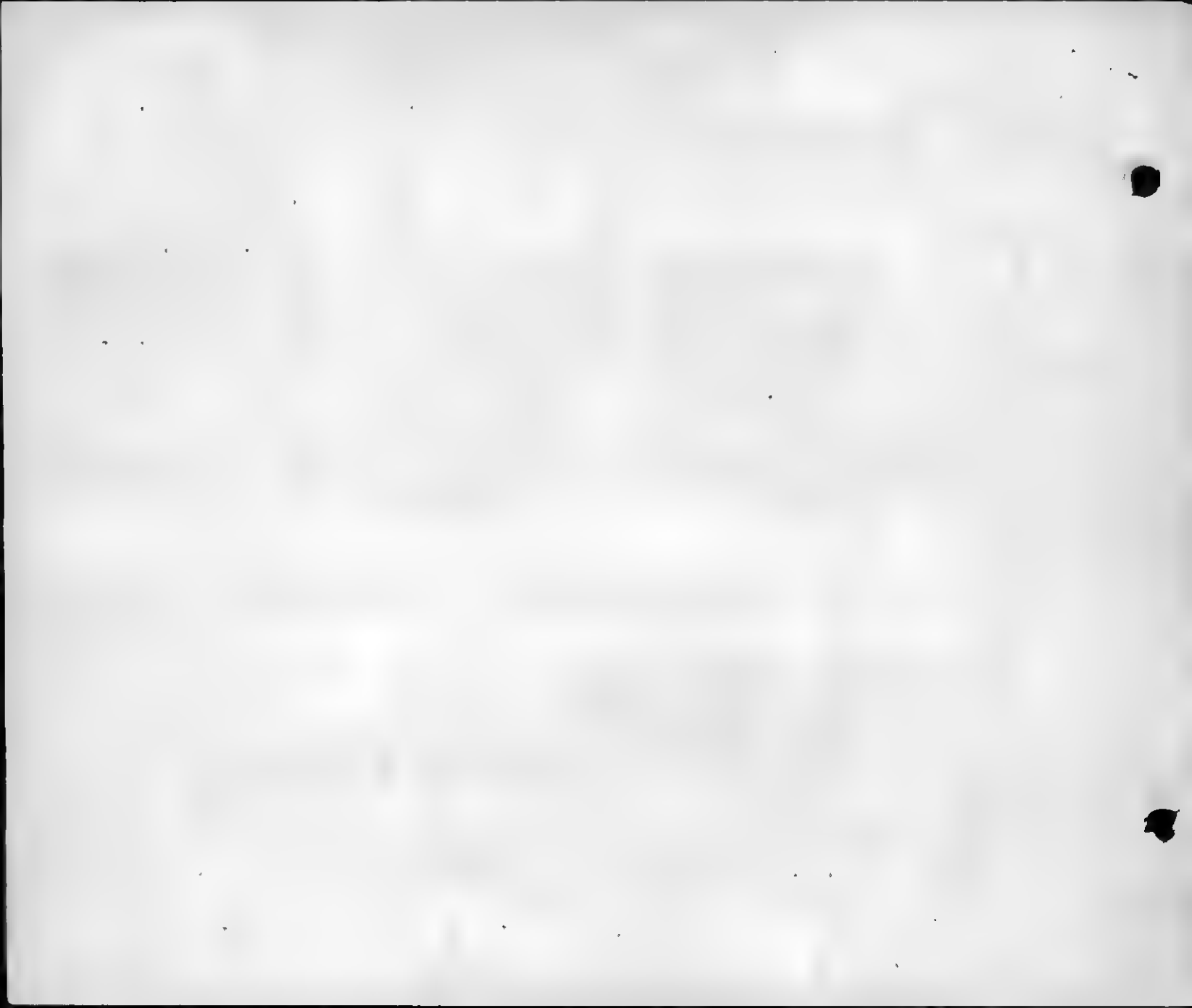
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01634

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">1651</span> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oaklee Village 29</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Oaklee Village 29</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>161 Colchester Rd.</u>		e. STREET ADDRESS <u>11 Colchester Rd.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>E L L A</u> <sup>First</sup> <u>W</u> <sup>Middle</sup> <u>Hoffman</u> <sup>Last</sup>		<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>01</u> Year <u>1960</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Feb. 12, 1883</u>
<b>9. AGE</b> (In years last birthday) <u>76</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Home</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home Duties</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>Otto L. Bauman</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Frances Mewshaw</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>no</u>	
<b>17. INFORMANT</b> <u>Walter W. Hoffman</u>		<b>Address</b> <u>1225 N. ...</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>Acute cardiac congestion</u>  <u>443X</u> <b>DUE TO</b> <u>Extensive cardiovascular heart disease</u>  <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>  <b>(b)</b> <u>  </u>  <b>DUE TO</b> <u>  </u>  <b>(c)</b> <u>  </u> </div>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>  </u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>20c. TIME OF INJURY</b> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>	<b>20f. (City or town)</b> (County) (State) <u>  </u>
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
<b>SIGNATURE</b> <u>Geo. B. M. Kieffer</u>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>	
<b>EXAMINER'S NAME (Type)</b> <u>Geo. B. M. Kieffer M.D.</u>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>	
<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <u>Feb. 01, 1960</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>22b. DATE THEREOF</b> <u>2/11/60</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore Cem.</u>	<b>22d. LOCATION</b> (City, town, or county) (State) <u>Balto Md.</u>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Howard H. Hubbard</u>		<b>24. REGISTRAR'S SIGNATURE</b> <u>  </u>	
<b>ADDRESS</b> <u>Fun'l Home 4107 Wilkens Ave.</u>		<b>DATE</b> <u>Feb. 12 '60</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

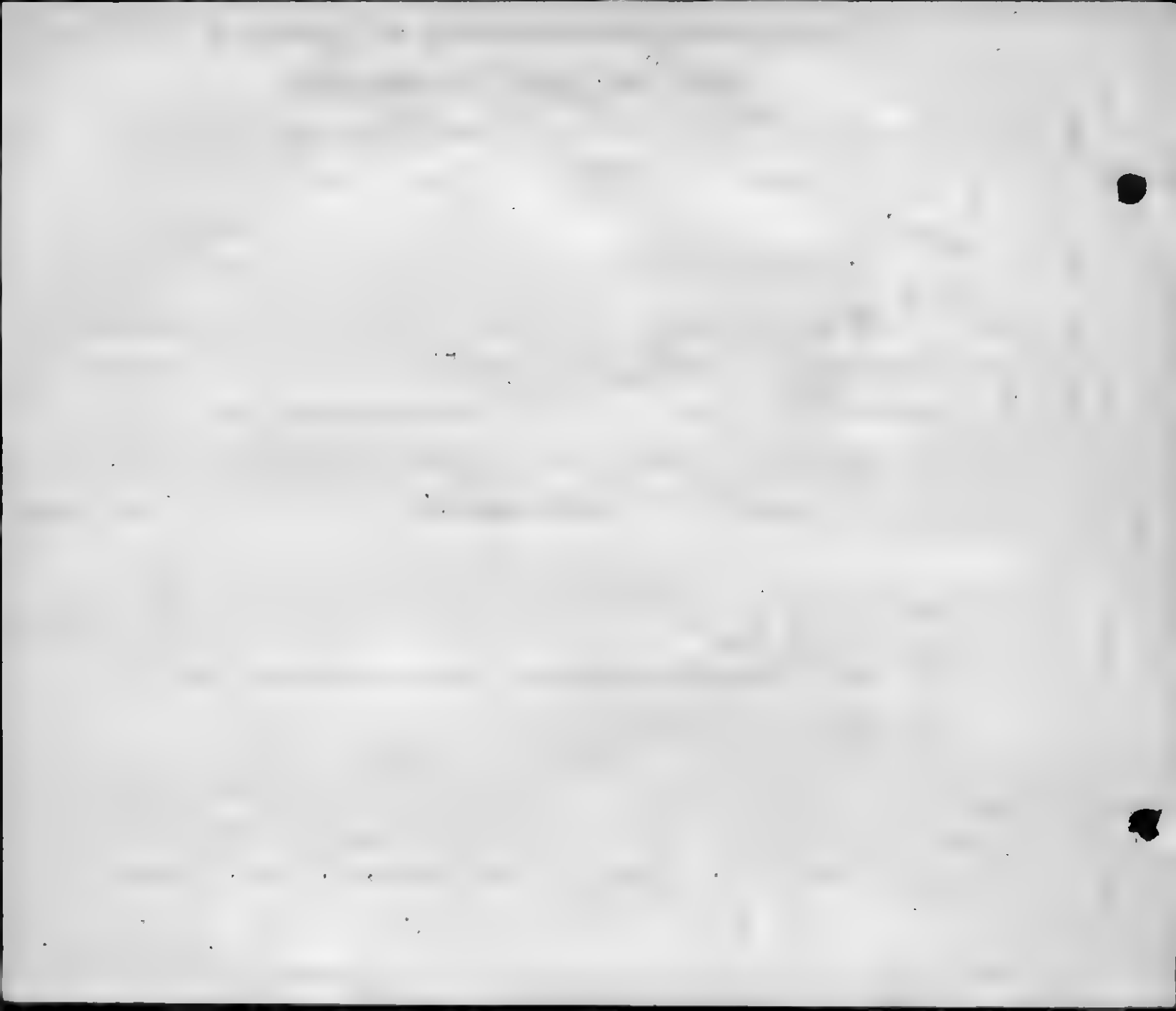
01635

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1652

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		STATE <u>MARYLAND</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mt. Wilson</u>		LENGTH OF STAY (In this place) <u>3 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>LAUREL</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>6564 L.P. ...</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>OSCAR JOHN HOOK</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>2-28-1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>XXXX-86</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>VA. York Co., Balto</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>OSCAR J HOOK, SR.</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE A. ELSH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u> <u>Mt. Wilson State Hospital</u>			
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>1 WEEK</u>	
IMMEDIATE CAUSE (A) <u>FAIR ADVANCED, ...</u>							
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M. from the causes and on the date stated above.							
SIGNATURE <u>Wm. Newcomer, M.D. Superintendent, Mt. Wilson, Maryland</u>				DATE SIGNED <u>2-28-60</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/2/60</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>MAR 1 '60</u>		REGISTRAR'S SIGNATURE <u>Charles L. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>2601 E. Madison St.</u>			



15 (4)  
9/SB

Item 1 Milwaukee 2-16-60 et

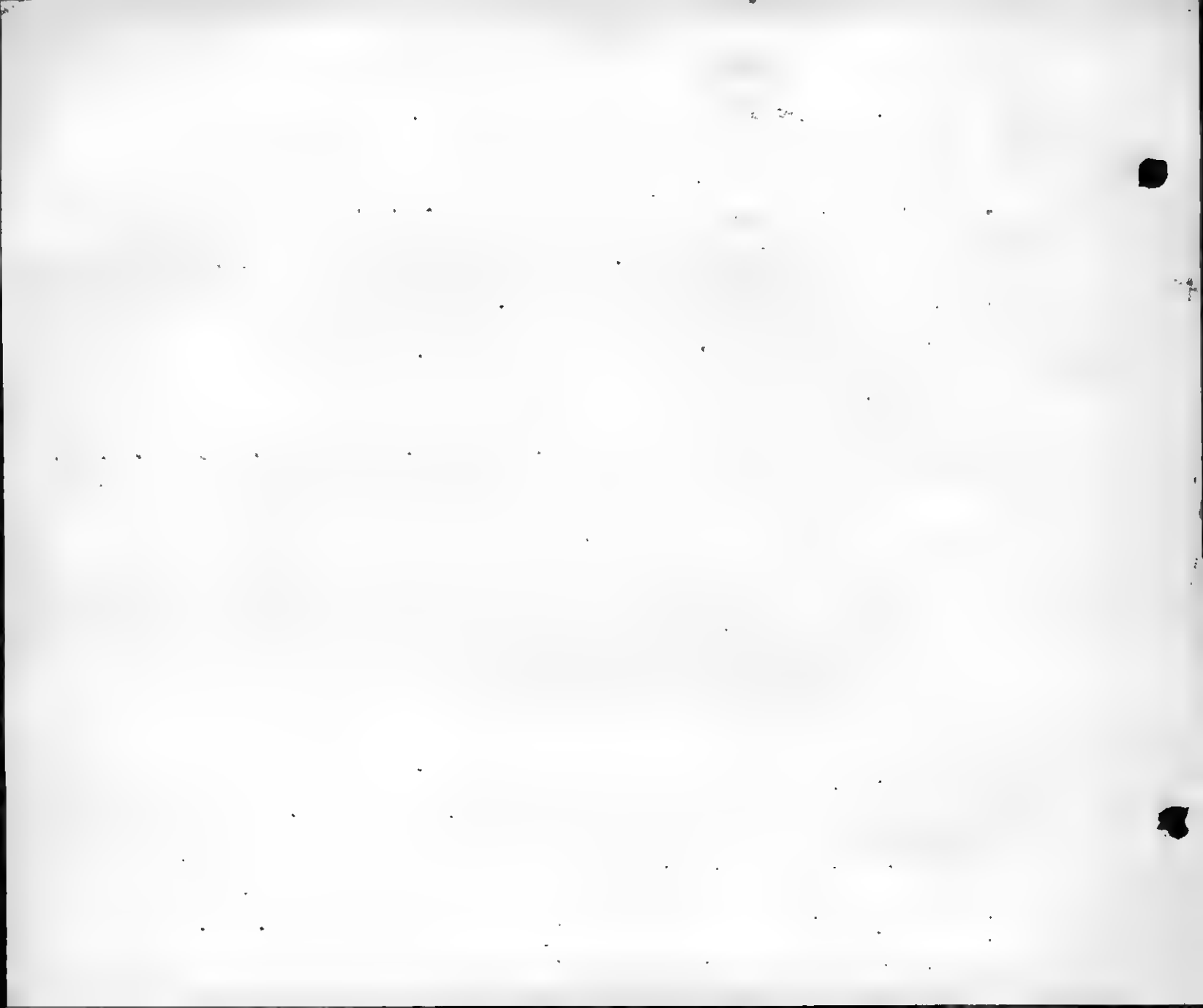
## Reg. Dist. No.

01636

1653

1. PLACE OF DEATH a. COUNTY <u>Howard</u> <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived if institution Reside before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>12</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Daughters of the Eucharist</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>	
f. STREET ADDRESS <u>Ligon Rd. R. F. D. 5</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>E. HOPWOOD</u> Last <u></u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 25, 1885</u>	
9. AGE (In years last birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
13. BIRTHPLACE (State or foreign country) <u>Md.</u>		14. CITIZEN OF WHAT COUNTRY? <u></u>	
15. FATHER'S NAME <u>George Kraft</u>		16. MOTHER'S MAIDEN NAME <u>Amelia Schwartz</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		18. SOCIAL SECURITY NO. <u></u>	
19. INFORMANT <u>Mr. Charles A. Hopwood, Jr.</u>		20. Address <u>Ligon Rd. R. F. D. 5</u>	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY HEART DISEASE</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROSIS</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u></u>	
23a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		23b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
23c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		23d. (City or town) (County) (State) <u></u>	
24. I certify that I attended the deceased from <u>1/8</u> , 19 <u>58</u> , to <u>2/7</u> , 19 <u>60</u> that I last saw the deceased alive on <u>2/6</u> , 19 <u>60</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.		25. ADDRESS (Street, city or town, state) DATE SIGNED <u>3723 EDMUNDSON AVE BALTO. 29, MD.</u>	
26. ACTUAL SIGNATURE <u>Paul R Ziegler</u>		26. M.D. <u>3723 EDMUNDSON AVE BALTO. 29, MD.</u>	
27. PHYSICIAN'S NAME (Type) <u>PAUL R ZIEGLER</u>		27. ADDRESS <u>BALTO. 29, MD.</u>	
28a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		28b. DATE THEREOF <u>2/10/60</u>	
28c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		28d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
29. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. S. Pickner &amp; Sons - Balt.</u>		29a. REC'D BY REGISTRAR DATE <u>FEB 9 '60</u>	
29b. REGISTRAR'S SIGNATURE <u>Arthur S. Thrush</u>		29c. ADDRESS <u></u>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1552

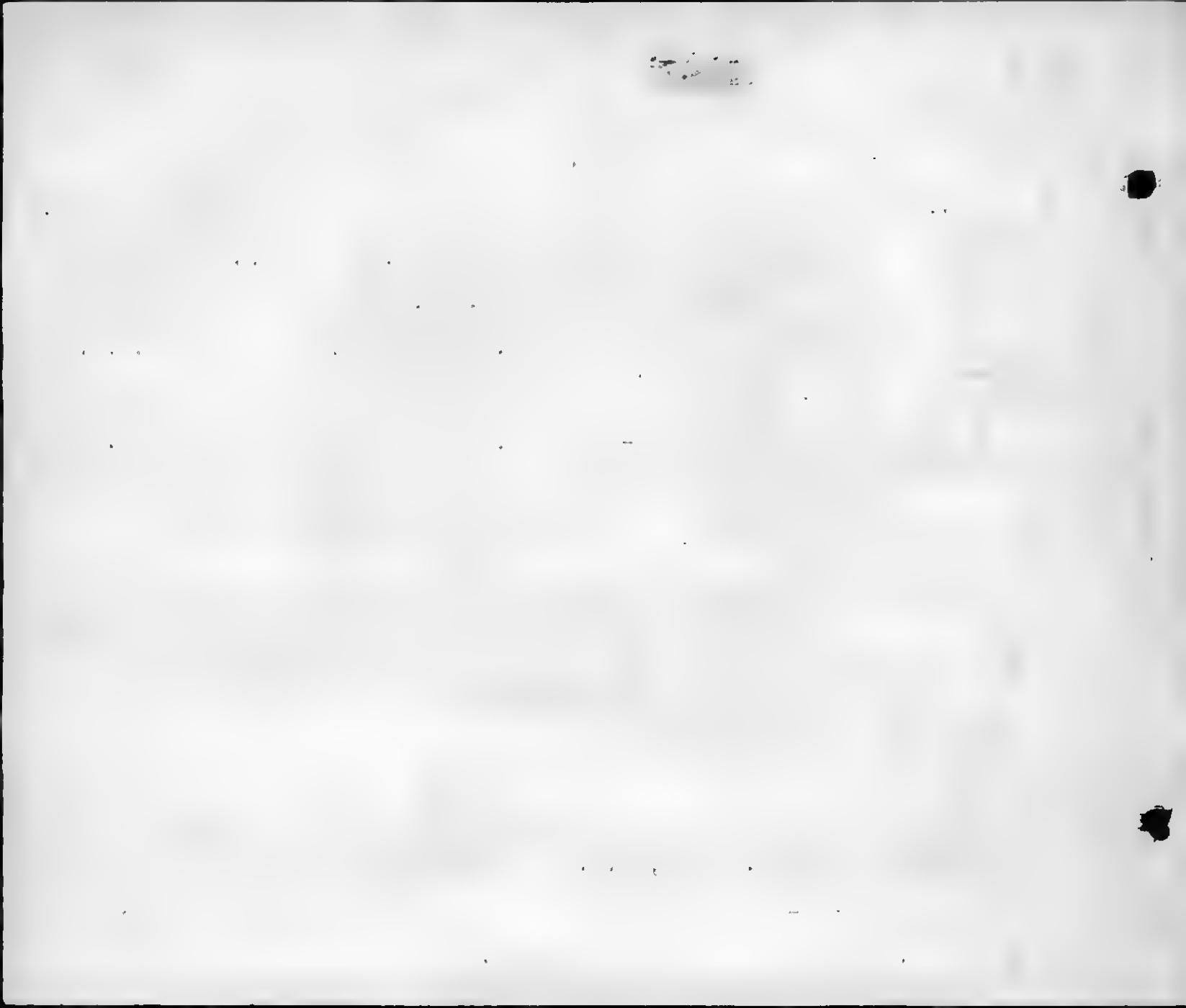
Reg. Dist. No.

01637

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>20 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Res., 711 Meadow Avenue</b>		e. STREET ADDRESS <b>711 Meadow Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Alfred Irvin Hubert Sr.</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>7,</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 13, 1926</b>
9. AGE (In years last birthday) <b>33 yrs</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>5</b>	11. IF UNDER 24 HRS Hours <b>5</b> M n. <b>5</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Consolidated Enk. Baltimore, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alfred W. Hubert</b>		14. MOTHER'S MAIDEN NAME <b>Helen Wloczewski</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-14-8057</b>	
17. INFORMANT <b>Mrs. Eula Hubert</b>		Address <b>711 Meadow Ave. 22, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumatic Carditis &amp; Mitral</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Stenosis + In soft. c. ency =</b> (c) <b>Stenosis + In soft. c. ency =</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Melvin B. Davis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>		DATE SIGNED <b>2/10/60</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-10-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>	22d. LOCATION (City, town, or county) (State) <b>Eastern Blvd, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda</b>		ADDRESS <b>7922 Wise Avenue 22, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 12 '60</b>		24b. REGISTRAR'S SIGNATURE <b>J. J. Duda</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. The certificate should be executed in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





1654

## CERTIFICATE OF DEATH

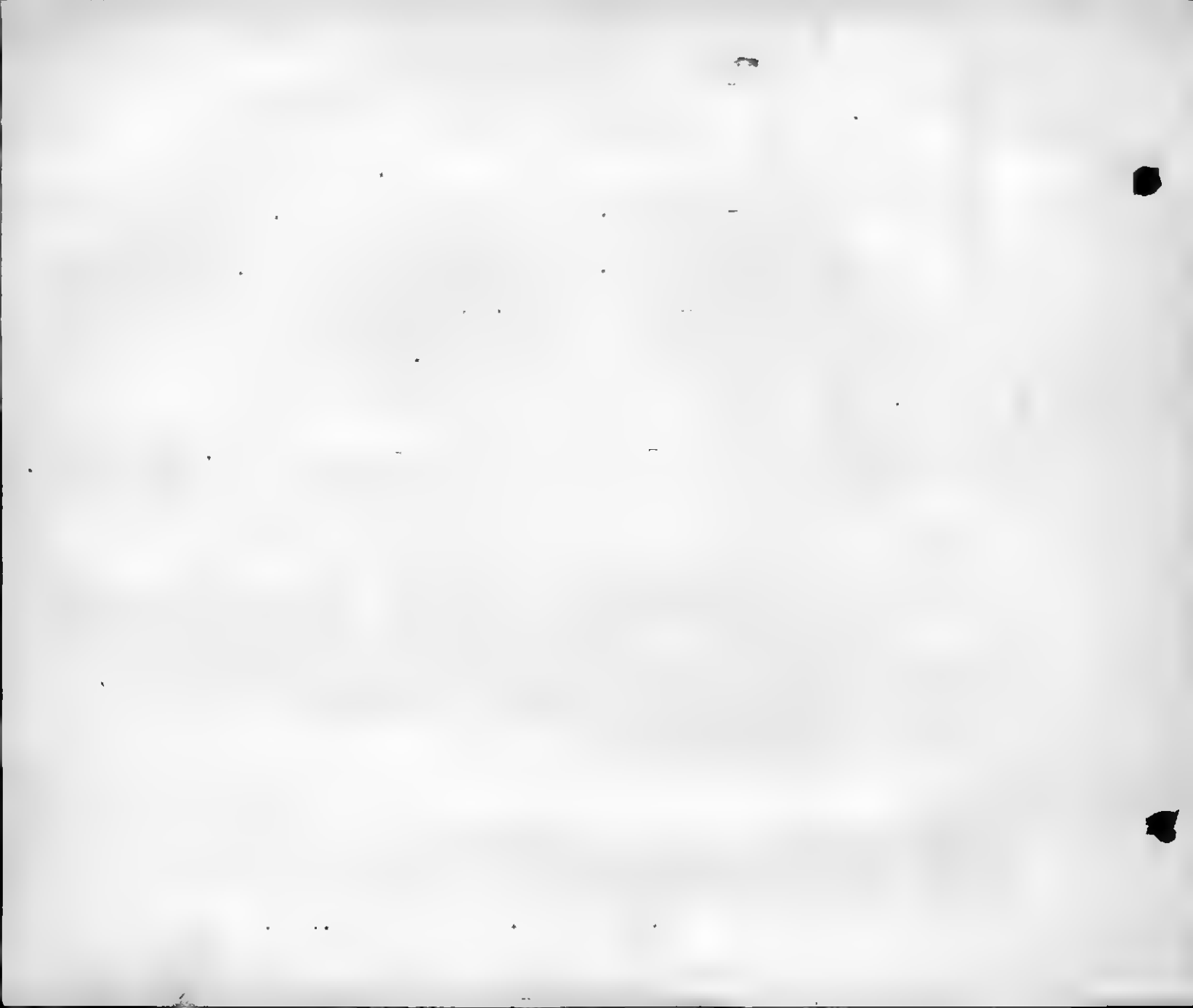
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Nursing Home-Rolling Rd.</b>				d. STREET ADDRESS <b>4644 Rokeby Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EUTHA</b> Middle <b>A.</b> Last <b>HUDSON</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>20</b> Year <b>19 60</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 7, 1882</b>		9. AGE (In years last birthday) <b>78 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>James H. Wood</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Catherine Downs</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Miss Ida Wood - 4644 Rokeby Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial insufficiency</b> <b>216X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pseudomucinous cystadenoma left ovary</b> (c) <b>intestinal obstruction, peritonitis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 wks - 4 yrs</b> <b>7/1/70</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 22 1955</b> to <b>Feb 20 1960</b> , that I last saw the deceased alive on <b>Feb 20 1960</b> , and that death occurred at <b>6:45</b> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4416 Edmondson Ave Balto., Md.</b> DATE SIGNED <b>Feb 21 1960</b>							
ACTUAL SIGNATURE <b>George A. Knipp</b> M.D.				PHYSICIAN'S NAME (Type) <b>George A. Knipp, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/23/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tiekner &amp; Sons - Balto.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 24 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Caring E. Kruza</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

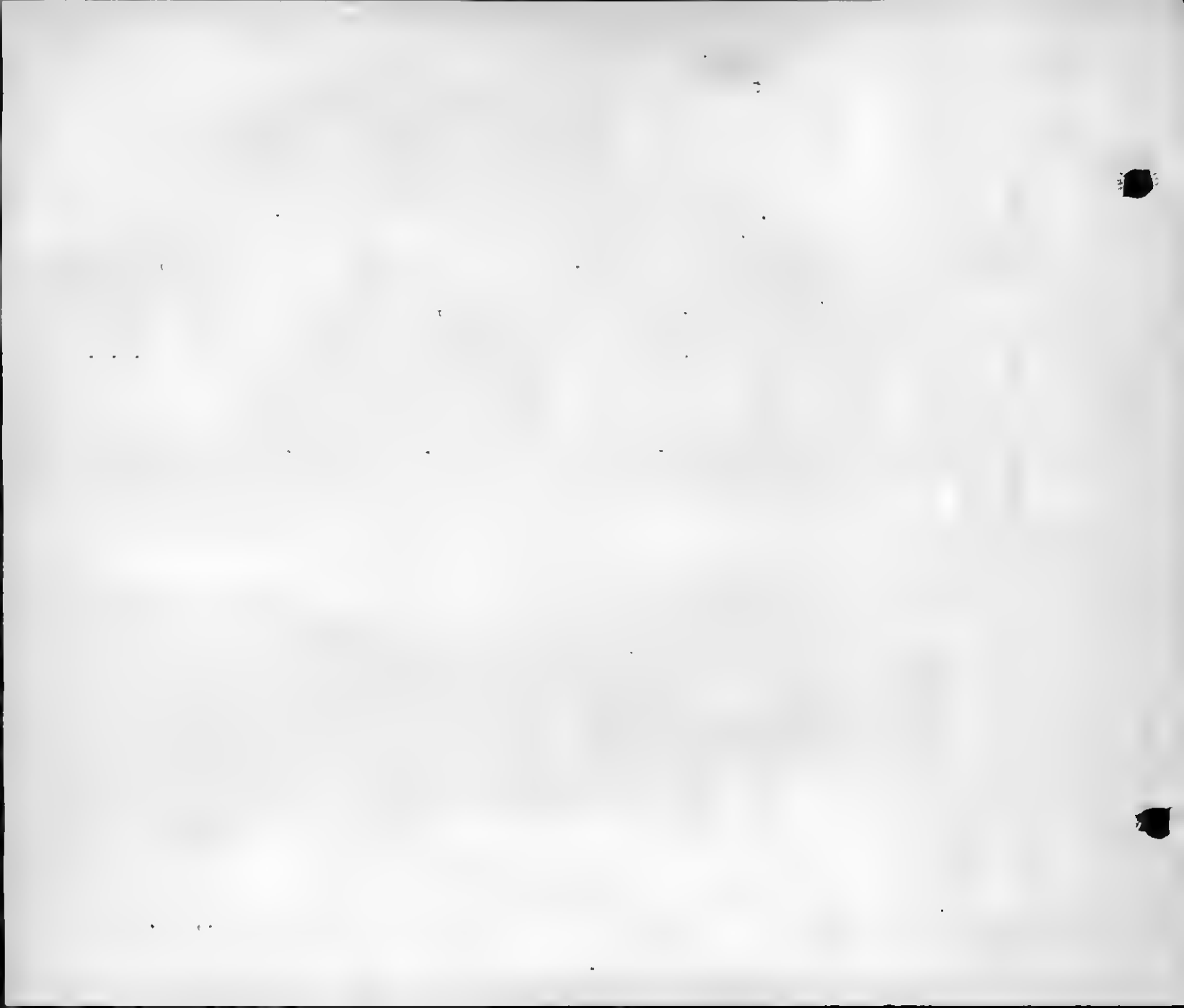
01639

1655

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex (21)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Essex (21)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>333 George Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN FRANK HUPPMAN SR.</u>		4. DATE OF DEATH <u>February 16, 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
11. IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Huppmann</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>705-03-9402</u>	
17. INFORMANT <u>John F. Huppmann Jr.</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-C-V-Disease</u>			
241X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Asthma (chronic)</u>			
DUE TO (c) <u>Asthma (chronic)</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u>		DATE SIGNED <u>2/16/60</u>	
EXAMINER'S NAME (Type) <u>M.B. DAVIS MD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/19/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Morland Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Bruzdinski</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
24b. REGISTRAR'S SIGNATURE <u>James Bruzdinski</u>		DATE <u>FEB 19 60</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

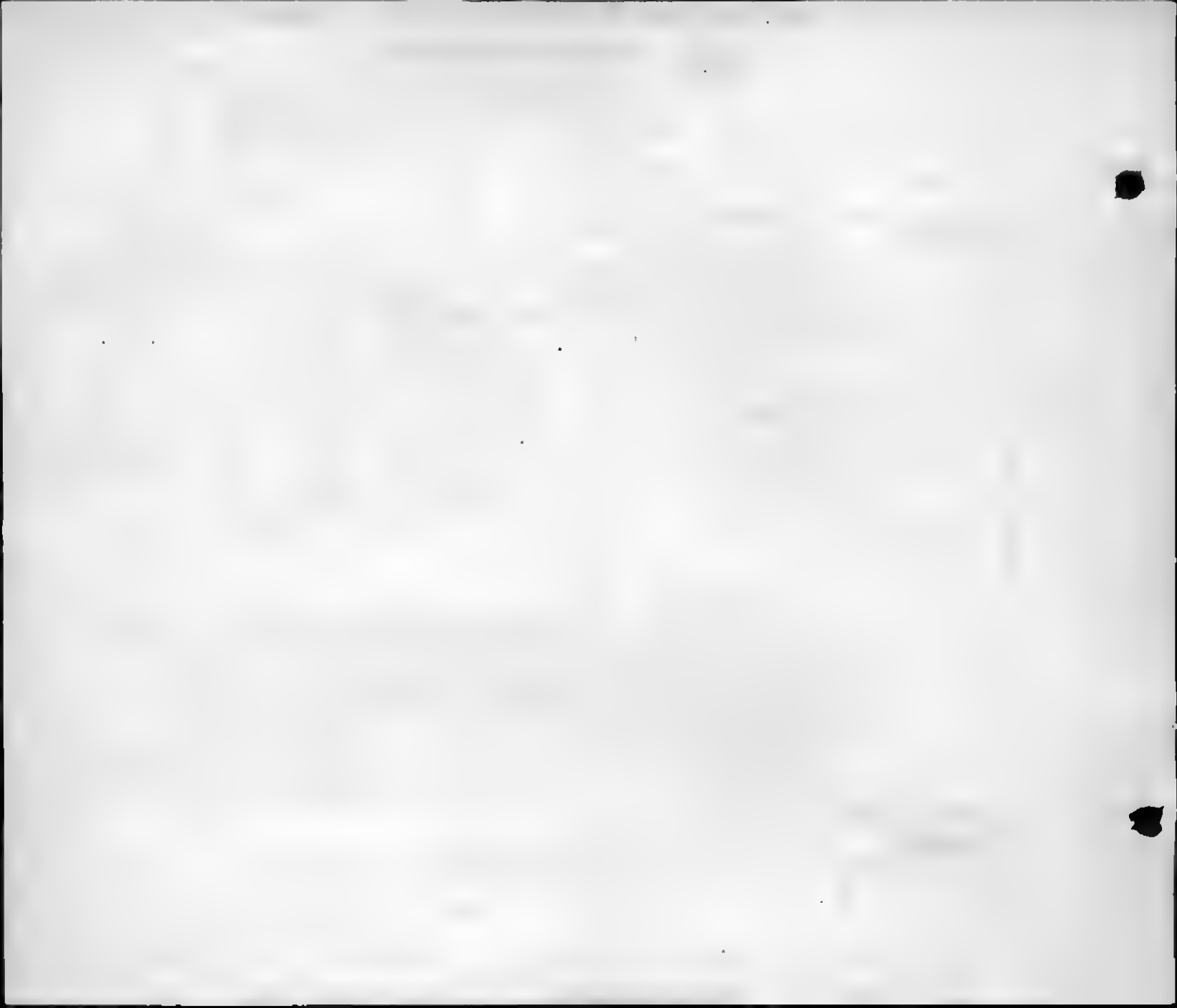
Reg. Dist. No.

01640

1656

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville 28</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The House in the Pines 16 Rusting Avenue</u>				d. STREET ADDRESS <u>104 East Madison Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Irving</u> Last <u>Irving</u>				4. DATE OF DEATH Month <u>February</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 10, 1885</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales lady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hutzler's Bro.</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>215-10-6587</u>		17. INFORMANT <u>Mrs. Louis Roche, 301 Gittings Avenue</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Decomposition</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary sclerosis</u> DUE TO (c) <u>Chs. Hypertensive Cardio-Vascular Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>5 yr.</u> <u>5 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-17-</u> , 19 <u>59</u> , to <u>2-22-</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-21-</u> , 19 <u>60</u> , and that death occurred at <u>6:30 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter K. Gallagher</u>				ADDRESS (Street, city or town, state) <u>6209 Frederick Ave Baltimore-28 Md.</u>			
DATE SIGNED <u>2-23-60</u>							
PHYSICIAN'S NAME (Type) <u>Walter K. Gallagher</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-25-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial P rk</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore County</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR <u>FEB 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
165 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01641

Items 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1711 W. Victoria Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last A. C. Williams		4. DATE OF DEATH —Month—Day—Year Feb. 13, 1960 19	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1918
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME William A. Jensen		14. MOTHER'S MAIDEN NAME Alice R. Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE Geo. S. M. Kieffer		DATE SIGNED Feb. 13, 1960	
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-17-60	
22c. NAME OF CEMETERY OR CREMATORY National Cemetery		22d. LOCATION (City, town, or county) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Hensley		24a. REC'D BY REGISTRAR DATE FEB 17 '60	
ADDRESS 578 W. Biddle St.		24b. REGISTRAR'S SIGNATURE	





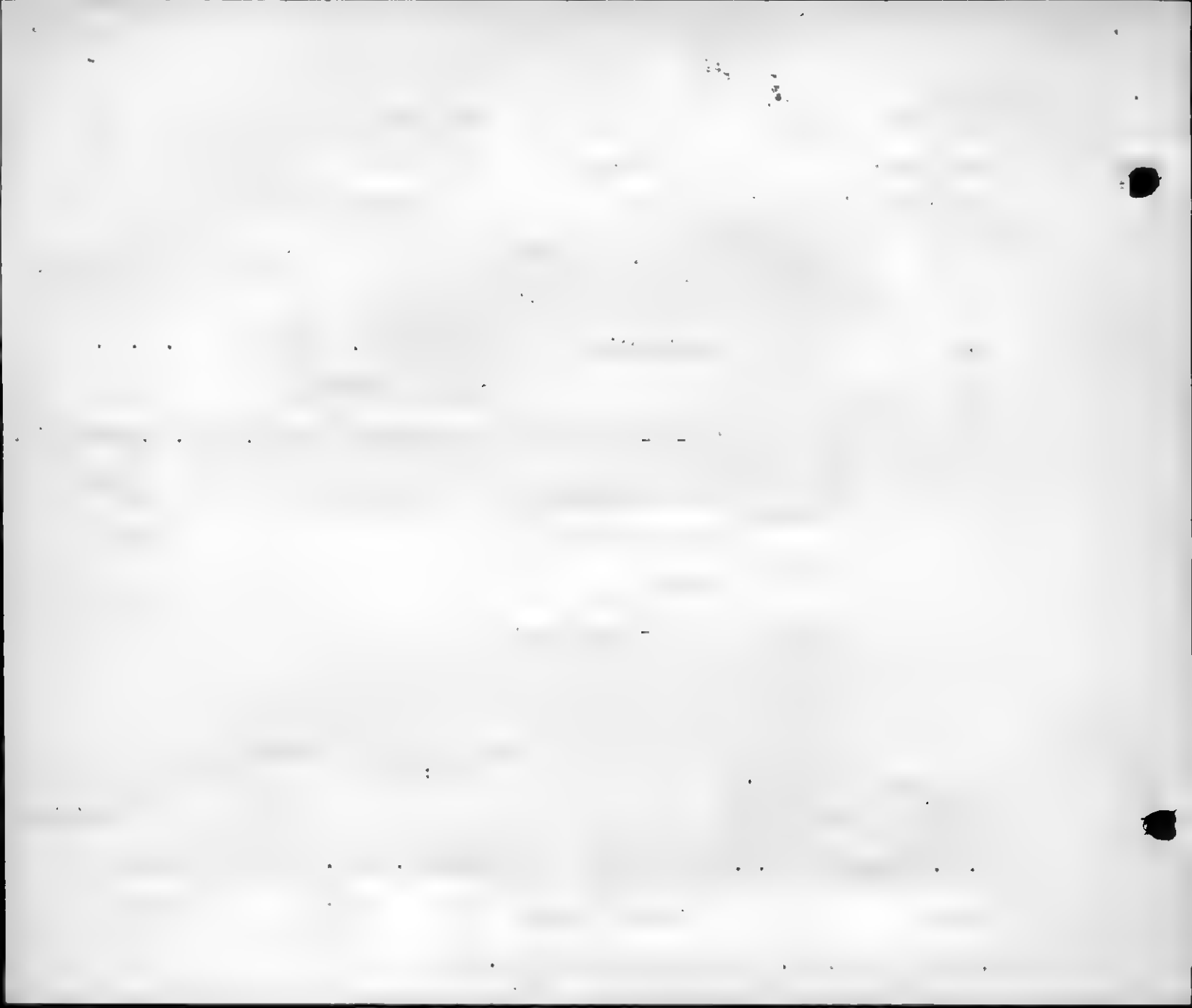
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1655  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

01642

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>90 Days</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>1</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> (6) d. STREET ADDRESS <b>1312 Evinger Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <b>LAWRENCE</b> Middle <b>E.</b> Last <b>JOHNSON</b>				<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>4</b> Year <b>1960</b>					
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>March 19, 1894</b>		<b>9. AGE</b> (In years last birthday) <b>65</b> IF UNDER 1 YEAR Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Engineer</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Construction</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore Co., Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>John Johnson</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Schreiber</b>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b>		<b>16. SOCIAL SECURITY NO.</b> <b>WW I 217-09-7999</b>		<b>17. INFORMANT</b> Address <b>Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DIABETES MELLITUS</b> (c) <b>PNEUMONITIS</b>								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>SUDDEN</b> <b>UNKNOWN</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>ABOVE KNEE AMPUTATION, LEFT -Operation 1/21/60</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 6, 1959</b> to <b>February 4, 1960</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Feb. 4, 1960</b> and that death occurred <b>8:45 AM</b> , from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <i>W. J. Pijanowski</i> <b>W. J. PIJANOWSKI, M.D.</b>				<b>22b. DATE SIGNED</b> <b>2/4/60</b>		<b>22c. PHYSICIAN'S NAME</b> (Typed) <b>VAH, BALTO. 18, MD. FORT HOWARD DIVISION</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>2-6-60</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Moreland Memorial Park</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Baltimore Maryland</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. Cook-Blight, Inc. 6009 Harford Road, Balto. 14 Md.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DATE FEB 8 '60</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kraus</i>			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

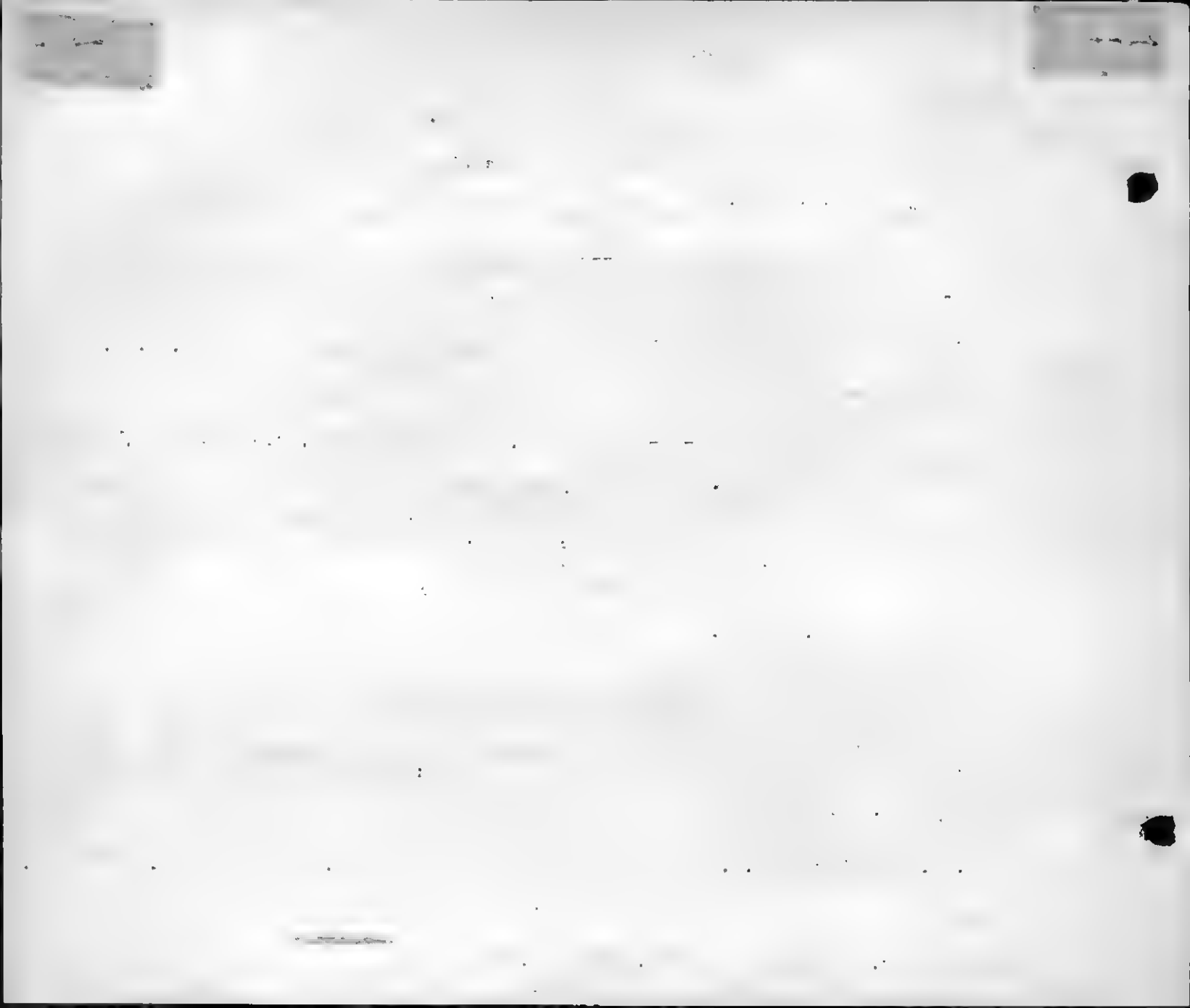
**1659 CERTIFICATE OF DEATH**

01643

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>30 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MOSES</b> Middle <b>---</b> Last <b>JOHNSON</b>				4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>19 60</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 20, 1895</b>		9. AGE (In years last birthday) <b>64</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joshua Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 218-10-4999</b>		17. INFORMANT Address <b>Division Clin. Records, VAH, Balto. 18, Maryland, Ft. Howard/</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA WITH PULMONARY EDEMA</b> DUE TO <b>HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE</b> <b>ARTERIOSCLEROSIS, MARKED, GENERALIZED</b> (b) <b>XXXXX SPLENIC INFARCTS, MULTIPLE</b> (c) <b>BENIGN PROSTATIC HYPERTROPHY,</b>						INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CEREBRAL EDEMA, RECENT.</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 19 19 60</b> to <b>February 18 19 60</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>2/18/ 1960</b> , and that death occurred on <b>2/18/ 1960</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>W. J. Pijanowski</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2/19/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. J. PIJANOWSKI, M.D.</b>				22d. ADDRESS <b>VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.</b>			
23a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/24/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore, Maryland</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>				25a. REC'D BY REGISTRAR <b>FEB 24 1960</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Piana</i>	
ADDRESS <b>1808 N. Monroe St. Balto 17, Md.</b>				DATE <b>FEB 24 1960</b>			

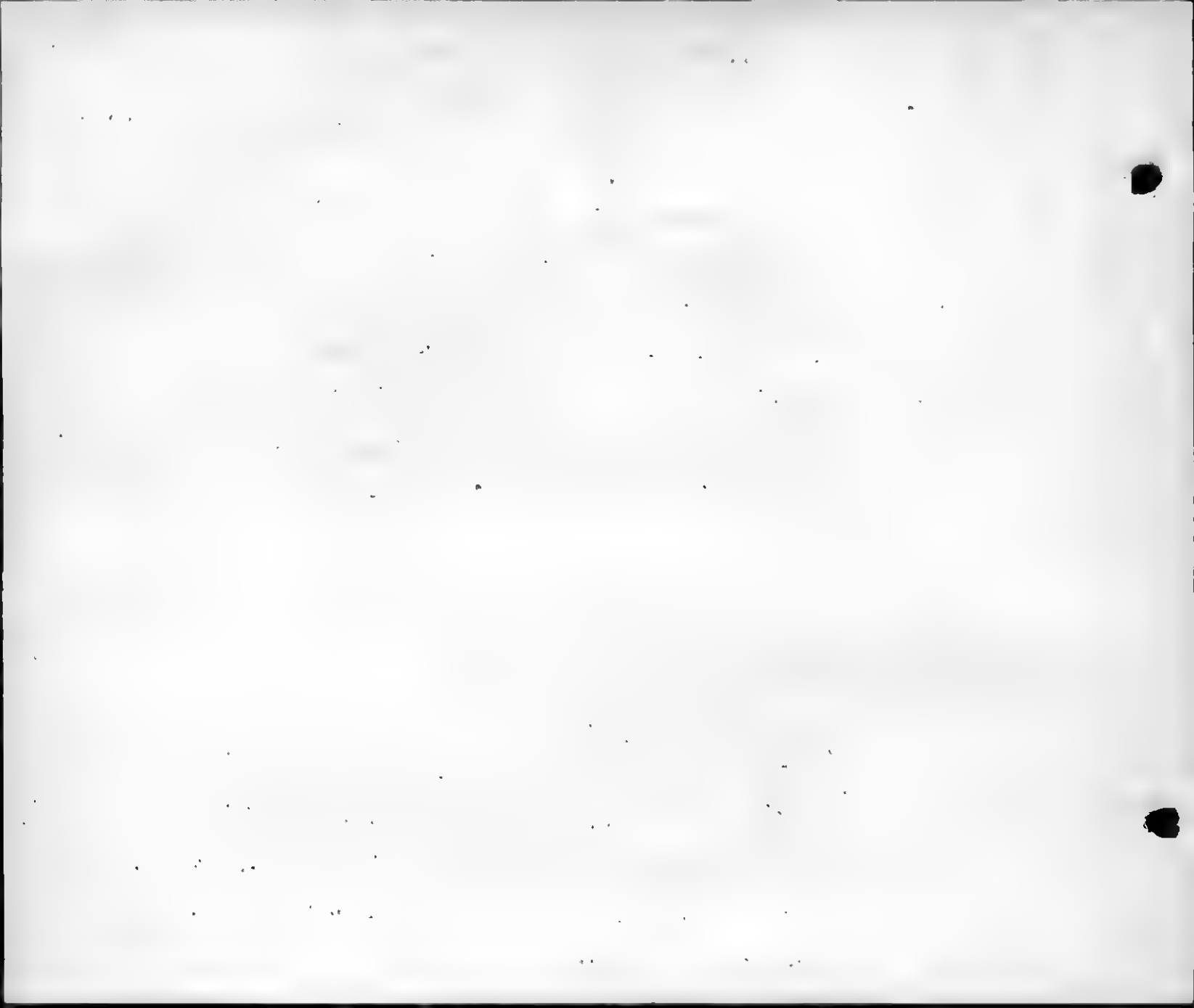
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## Reg. Dist. No.

MEDICAL CERTIFICATION

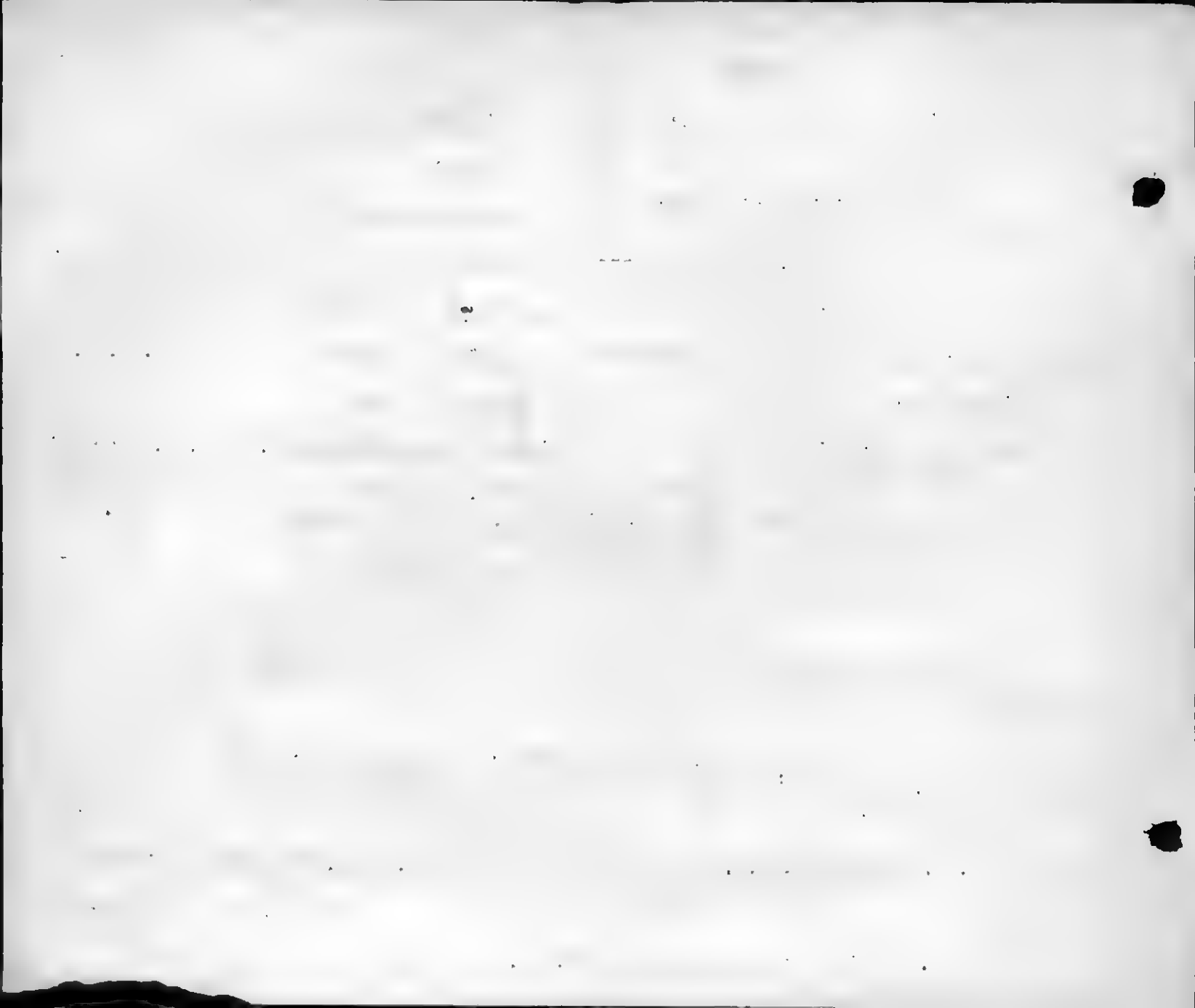


TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1661  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
1661  
CERTIFICATE OF DEATH

01645

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>164 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>Route #3, Box 101</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ARTHUR --- JONES</b>		4. DATE OF DEATH Month Day Year <b>February 29 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 13, 1892</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USCA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Easton, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Jones</b>		14. MOTHER'S MAIDEN NAME <b>Harriet Corness</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>	
17. INFORMANT <b>Clinical Records, VAH, Balto. 18, Md. Ft. Howard Division</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA, LEFT LUNG</b> <b>XXXX METASTATIC CARCINOMA, LIVER AND ADRENAL</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>BRONCHOPNEUMONIA, LEFT LUNG</b> <b>XXXX ARTERIOSCLEROSIS, MARKED, GENERALIZED</b> (c) <b>NEPHROSCLEROSIS, ARTERIOSCLEROTIC</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>RECENT</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>W</b> (this hospital) attended the deceased from <b>Sept. 18, 1959</b> to <b>Feb. 29, 1960</b> , that <b>W</b> (we) last saw the deceased alive on <b>6:59 AM 2/29/60</b> and that death occurred at <b>6:59 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W. J. Pijanowski</b>		22b. DATE SIGNED <b>2/29/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. J. PIJANOWSKI, M.D.</b>		22d. ADDRESS <b>VAH, BALTO. 18, MD. FORT HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-4-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Unionville Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Route One, Easton, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Dashiell</b>		25a. REC'D BY REGISTRAR <b>MAR 2 '60</b>	
ADDRESS <b>Funeral Home, Easton, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	





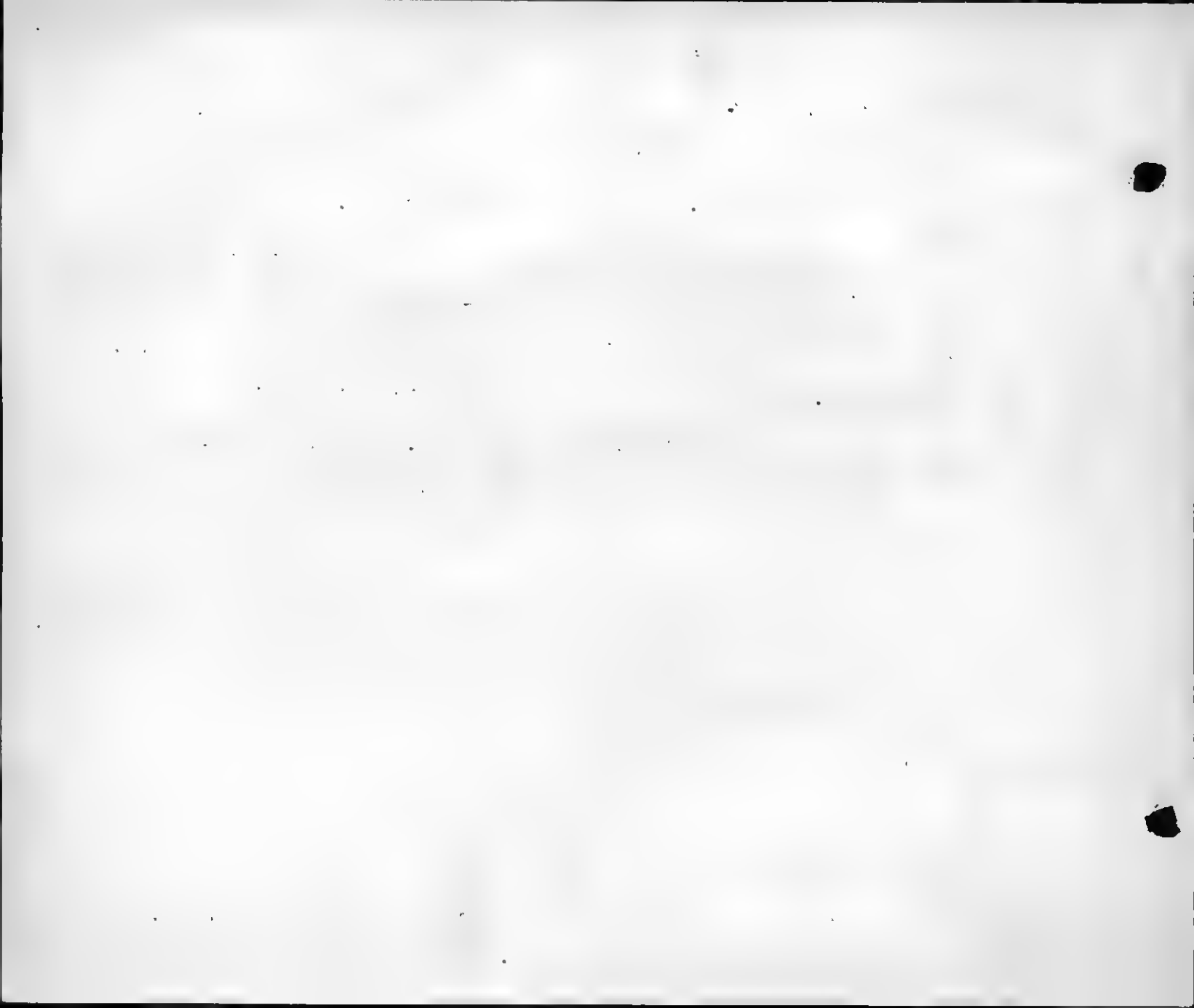
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admiss on) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Hall</b>		c. LENGTH OF STAY IN 1b <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Hall</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wiseburg Rd.</b>			d. STREET ADDRESS <b>Wiseburg Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>John Emory Jones</b> Middle Last			4. DATE OF DEATH Month <b>2-28-60</b> Day Year <b>19</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>X 7-24-1879</b>	9. AGE (In years last birthday) <b>86 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>paper mill</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Randolph R. Jones</b>			14. MOTHER'S MAIDEN NAME <b>Mary Virginia Bull</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-20-9428</b>		INFORMANT Address <b>Minnie V. Jones, above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>321X</b> DUE TO <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>after hours</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 27</b> , 19 <b>60</b> to <b>Feb 28</b> , 19 <b>60</b> that I last saw the deceased alive on <b>Feb 27</b> , 19 <b>60</b> , and that death occurred at <b>1 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <b>Milner Bortner</b> M.D.			PHYSICIAN'S NAME (Type) <b>Milner Bortner, M.D. White Hall, Maryland</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-2-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wiseburg Methodist</b>	
22d. LOCATION (City, town, or county) (State) <b>White Hall, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

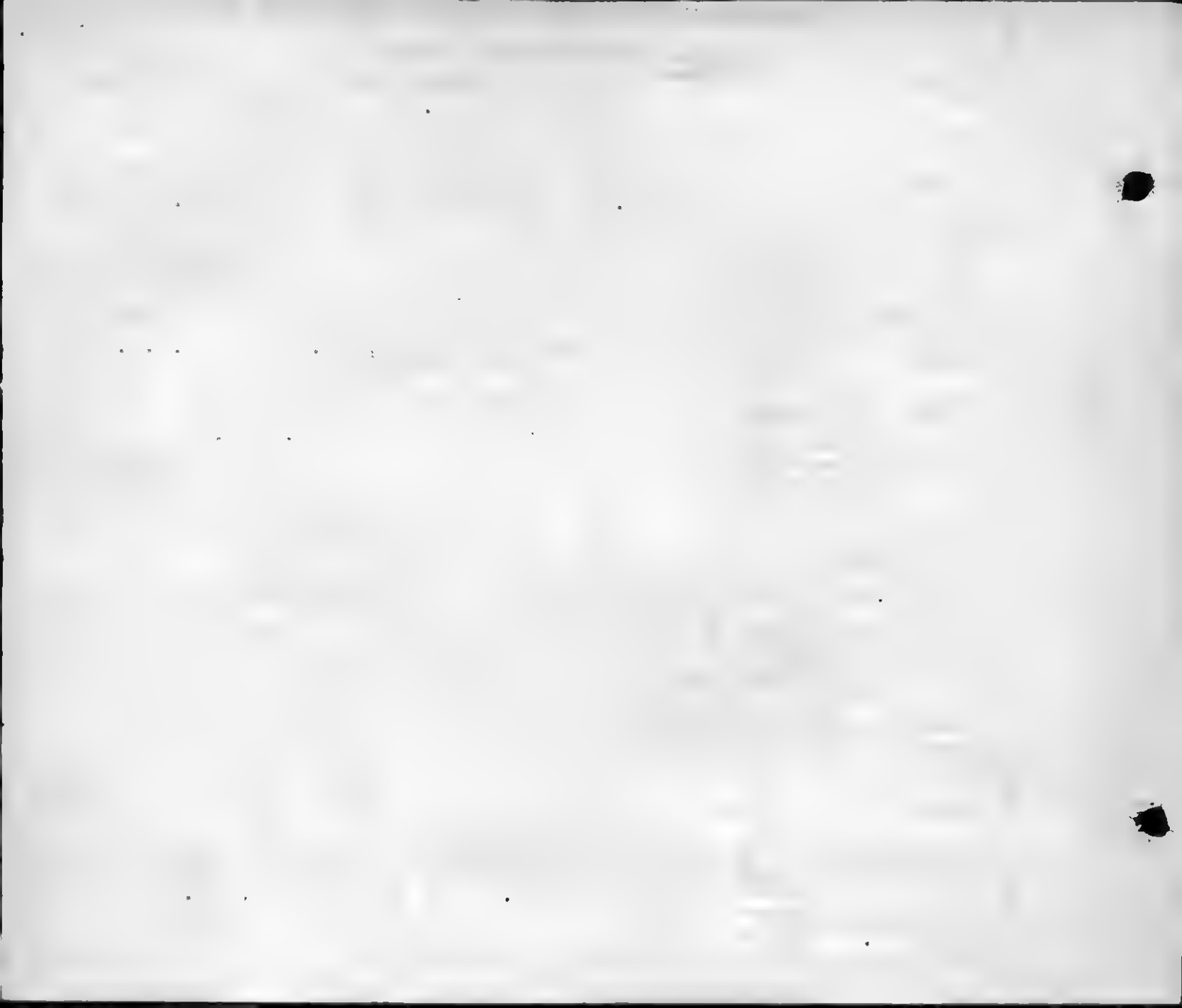
01647

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8058 Philadelphia Rd.</b>		e. STREET ADDRESS <b>8058 Philadelphia Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>J.</b> Last <b>Joska</b>		4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 1898</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months <b>61</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own business</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank J. Joska</b>		14. MOTHER'S MAIDEN NAME <b>Anna Liska</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Carrie Sellier Joska, wife, above</b>	
17. INFORMANT <b>Carrie Sellier Joska, wife, above</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma - Stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized - Metastasis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10/27/59?</b> <b>10/27/59?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/27, 1959</b> , to <b>2/20, 1960</b> , that I last saw the deceased alive on <b>2/20, 1960</b> , and that death occurred at <b>5 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Louis F. Klimes M.D.</b>		ADDRESS (Street, city or town, state) <b>2623 E. Monument St - 5</b>	
DATE SIGNED <b>2/22/60</b>			
PHYSICIAN'S NAME (Type) <b>LOUIS F. KLIMES M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/24/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Schimunek</b>		ADDRESS <b>Funeral Home 3331 Greens Lane</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 23 '60</b>		24b. REGISTRAR'S SIGNATURE <b>C. E. Schimunek</b>	

1 HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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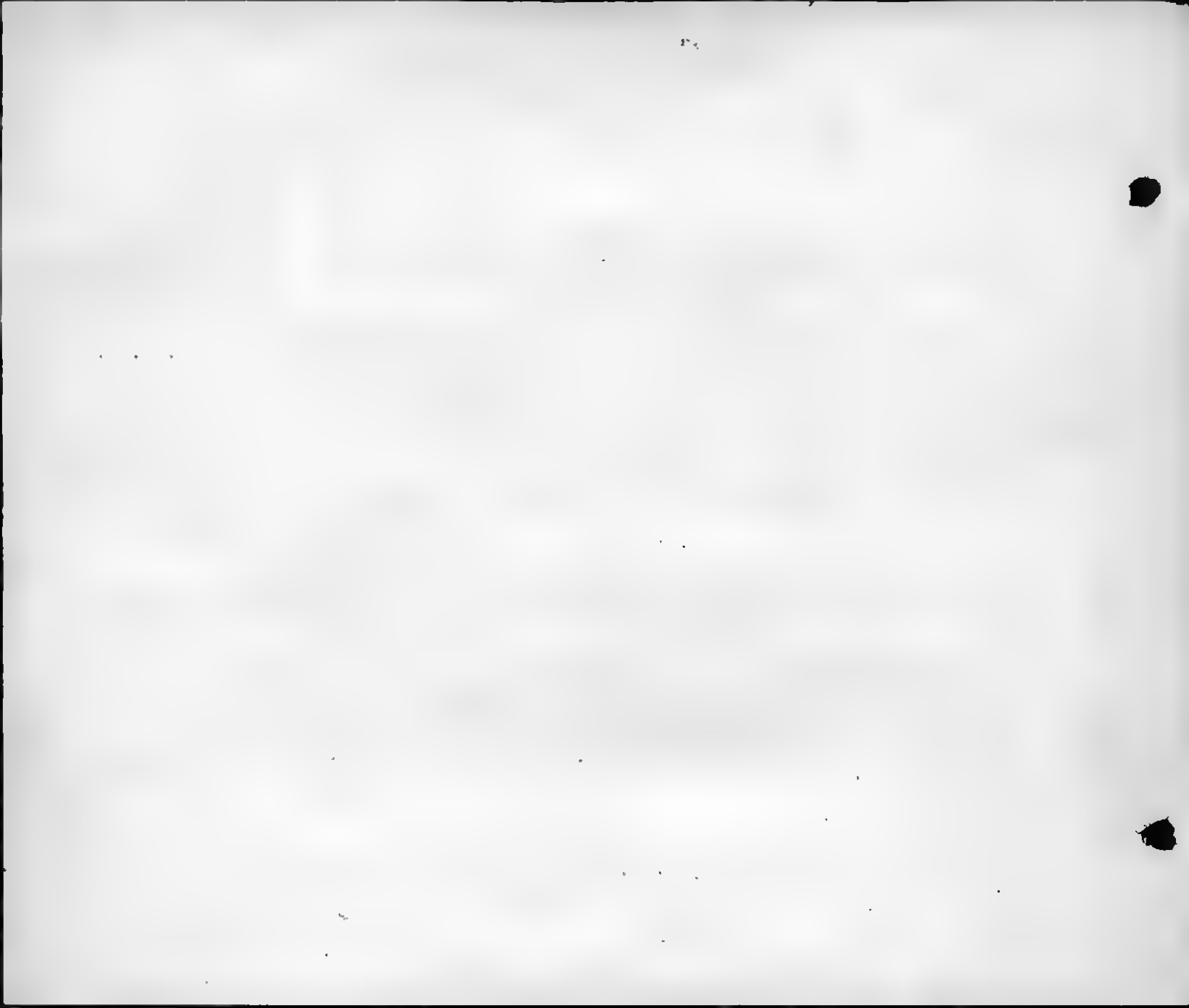
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1664

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>11yr3mth19dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>1232 Columbia Road</u> <u>Catonsville</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>J.</u> Last <u>Joyce</u>		4. DATE OF DEATH Month <u>February</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1686</u>
9. AGE (In years last birthday) <u>73</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>460.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 10, 1959</u> , to <u>Feb. 10, 1960</u> , that I last saw the deceased alive on <u>Feb. 10, 1960</u> , and that death occurred at <u>3:10p. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslar</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL 2-11-60</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		Address <u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2/12/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		22d. LOCATION (City, town, or county) (State) <u>4300 Old Frederick</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Bates</u>		ADDRESS <u>1318 Light</u>	
24a. REC'D BY REGISTRAR <u>FEB 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



1665 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

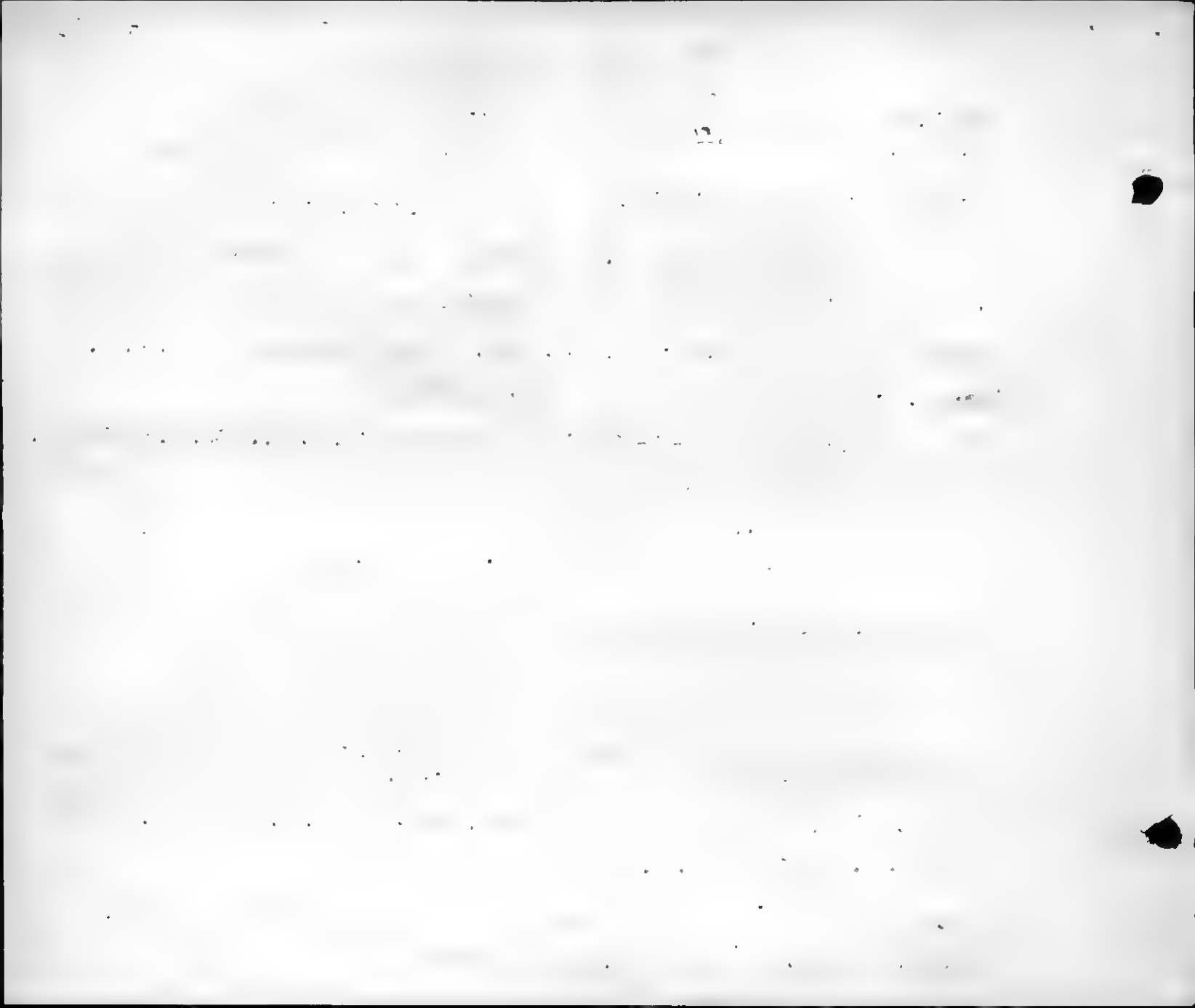
CERTIFICATE OF DEATH

Reg. Dist. No.

01649

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>4 Days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>26</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>1001 Fairhaven Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>B.</b> Last <b>JUMP</b>		4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>19 60</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 22, 1912</b>	
9. AGE (In years last birthday) <b>47 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		11. BIRTHPLACE (State or foreign country) <b>St. Michaels, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Giles H. Jump</b>		14. MOTHER'S MAIDEN NAME <b>Ethel Mary Marshall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>217-01-9346</b>		INFORMANT <b>Clinical Records VAH, Balto. 18, Md. FT. HOWARD DIV.</b>		Address		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION,</b> <b>420.1</b> DUE TO <b>CORONARY THROMBOSIS</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>XXX PULMONARY CONGESTION AND EDEMA, MARKED</b> (c) <b>RECENT</b>		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>	
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>ARTERIOSCLEROSIS, MODERATE, OLD</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>VA</b>		20g. (County)		20h. (State)		21. I certify that I attended the deceased from <b>January 31, 1960</b> to <b>February 4, 1960</b> and that death occurred on <b>1:10 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>M.D. VAH, BALTO 18, MD. FT. HOWARD DIV.</b>	
21. ACTUAL SIGNATURE <b>W. J. PIJANOWSKI, M. D.</b>		21. DATE SIGNED <b>2/4/60</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-4-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Saint Michaels, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hambleton Harrison</b>		23. ADDRESS <b>Saint Michaels, Maryland</b>		24a. REC'D BY REGISTRAR <b>SEP 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Thomas</b>		25. REGISTRAR'S SIGNATURE		26. REGISTRAR'S SIGNATURE	

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this cert. is filed, the funeral director must file it with the registrar within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1666

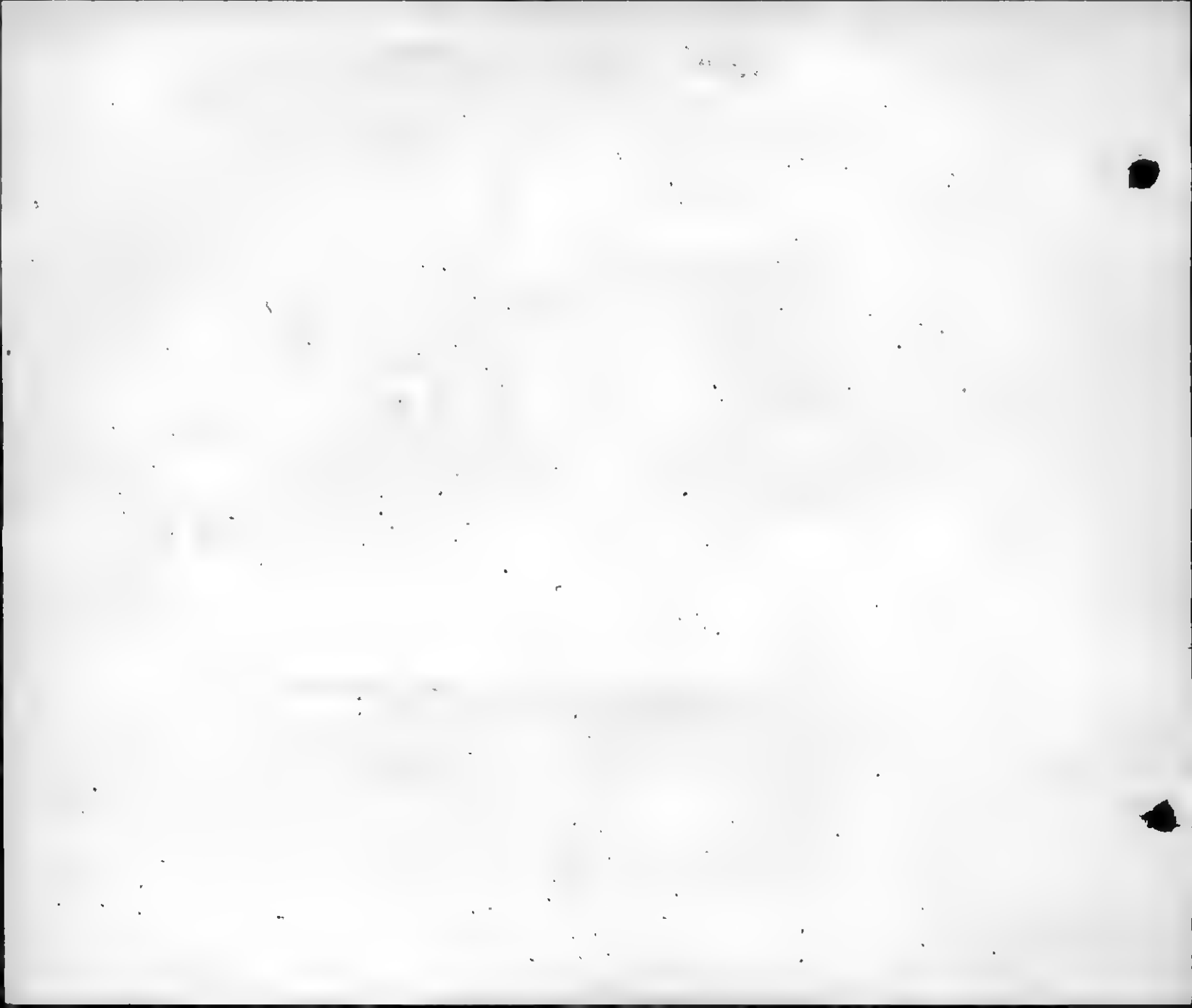
**CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>13 days</u>		d. STREET ADDRESS <u>3630 Bechtler Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>For High Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louis</u> Middle Last <u>Kabik</u>		4. DATE OF DEATH Month <u>2</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/8/1898</u> 9. AGE (In years last birthday) <u>62</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>London, Eng</u>	
11. BIRTHPLACE (State or foreign country) <u>London, Eng</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Matthew Kabik</u>		14. MOTHER'S MAIDEN NAME <u>Bessie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Informant</u> Address <u>Anna Kabik - Anne</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Metastases due to Hypopharyngeal</u> (b) <u>Hypopharyngeal Left = Pulmonary Metastases</u> (c) <u>Dehydration &amp; emaciation</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 10, 1959</u> to <u>Feb 17, 1960</u> , that I last saw the deceased alive on <u>Feb 17, 1960</u> , and that death occurred at <u>1:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. William Primack</u>		ADDRESS (Street, city or town, state) <u>Baltimore 17, Md</u>	
PHYSICIAN'S NAME (Type) <u>Dr. H. William Primack</u>		DATE SIGNED <u>Feb 17, 1960</u>	
22a. BURIAL, CREMATION, REMOVA. (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2-18-60</u>	<u>Hebrew Young Men</u>	<u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2106 Eutan Place</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 19 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01651

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Back River</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Back River</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X</b> <b>Back River</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>401 Island Point Road</b>			d. STREET ADDRESS <b>401 Island Point Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Matthew</b> Middle <b>Charles</b> Last <b>Kalb</b>			4. DATE OF DEATH Month <b>February</b> Day <b>14</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1892</b>		9. AGE (In years last birthday) <b>67</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <b>John Kalb</b>			14. MOTHER'S MAIDEN NAME <b>Mary</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Delores Harris</b> Address <b>233 N. Morlyn Avenue</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4-1-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 hr</b> <b>5 years</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Jack C. Collins</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2-15-60</b>	
EXAMINER'S NAME (Type) <b>JACK C COLLINS</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb 18, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>	
22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		22e. (State) <b>Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lilly &amp; Zeiler Inc., 1901 Eastern Avenue</b>			24a. REC'D BY REGISTRAR <b>FEB 17 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Walter S. Frank</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 12 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



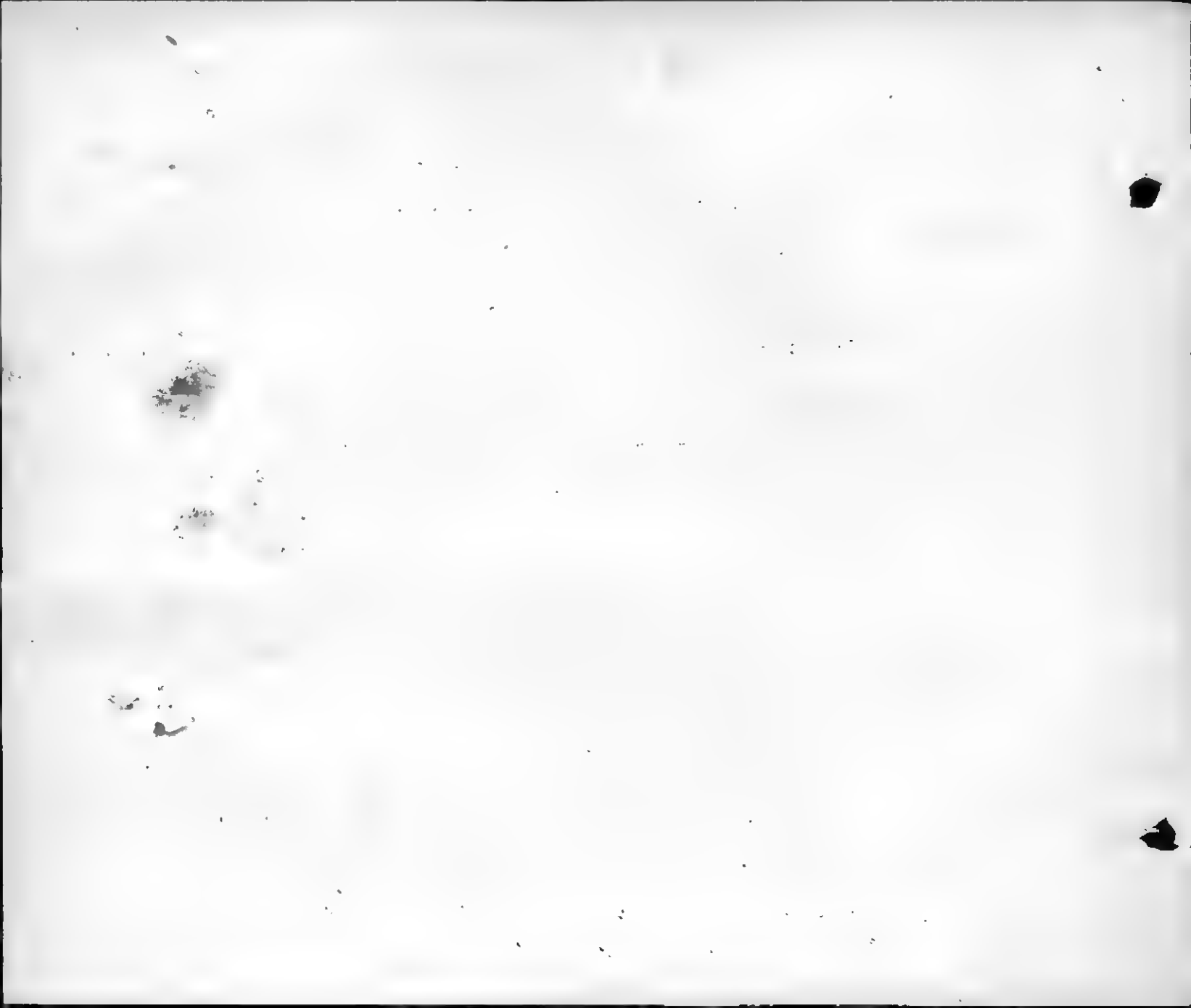
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1668. CERTIFICATE OF DEATH

01652

Reg./Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>5yr6mth18dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen, Maryland</b>	
f. STREET ADDRESS <b>R. F. D. #1</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>John</b> Last <b>Kalmbacher</b>		4. DATE OF DEATH Month <b>February</b> Day <b>22</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 11, 1883</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min. <b>76</b>	11. IF UNDER 24 HRS Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min. <b>76</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Decorative Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Kalmbacher</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Schantz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO <b>213-30-8713</b>	
INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA - BILATERAL</b> <b>H7IX</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 19</b> , 19 <b>60</b> , to <b>Feb. 22</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Feb. 22</b> , 19 <b>60</b> , and that death occurred at <b>6:50 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Anthony S. Garofano</b> M.D.		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>2-22-60</b>	
PHYSICIAN'S NAME (Type) <b>ANTHONY S. GAROFANO</b>		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 25 - 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bahrs Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Aberdeen Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Sarring</b>		ADDRESS <b>Aberdeen Maryland</b>	
24a. REC'D BY REGISTRAR <b>1</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Harris</b>	



1

1669

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

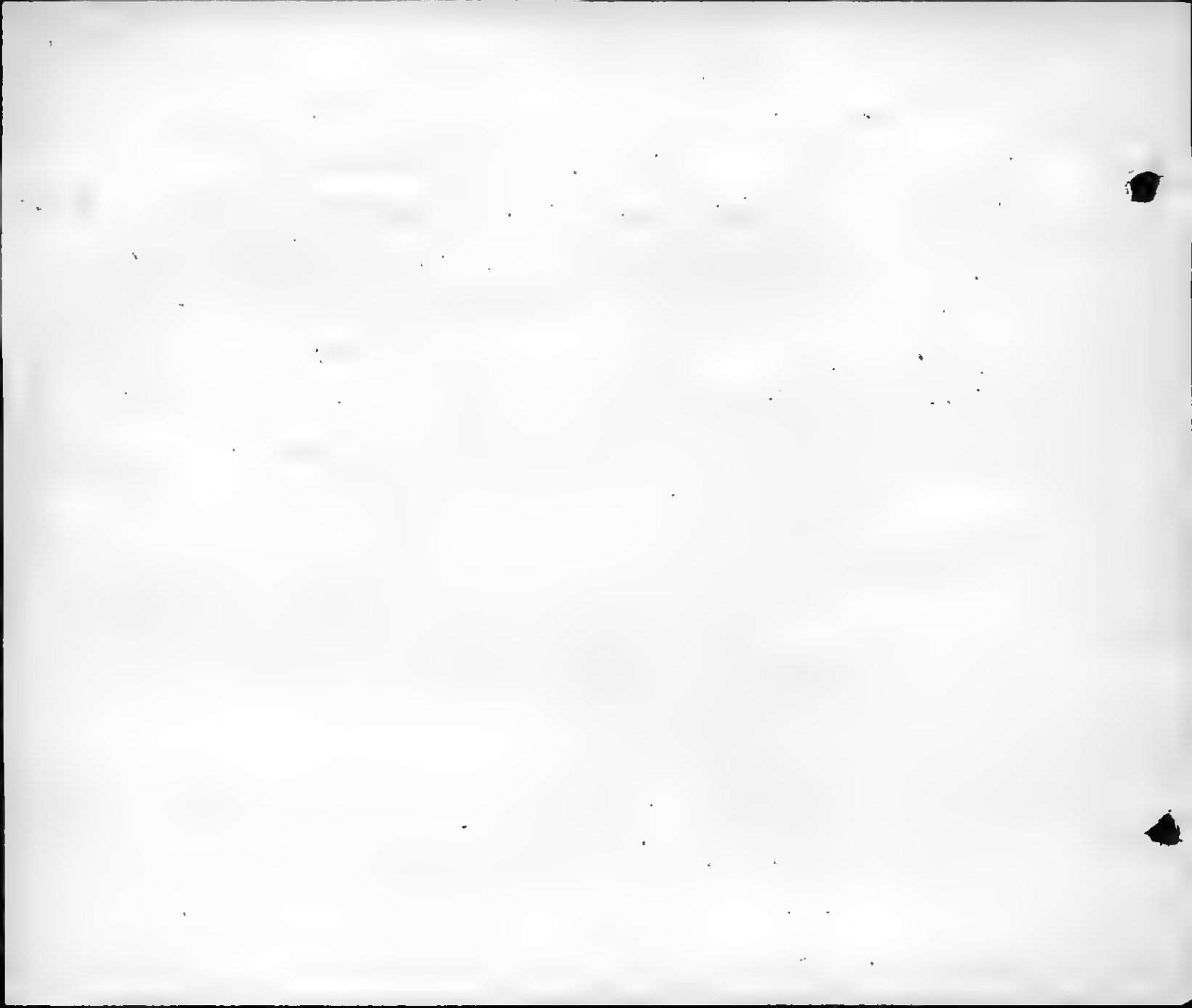
01653

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OWINGS Mills</b>		c. LENGTH OF STAY IN 1b <b>8 MONTHS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ROSEWOOD STATE TRAINING SCHOOL</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PEGGY VIRGINIA KAMPE</b>		4. DATE OF DEATH <b>FEBRUARY 15 1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 9, 1930</b>
9. AGE (in years last birthday) <b>29</b> yrs.		10. F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DOUGLAS FOSTER KAMPE</b>		14. MOTHER'S MAIDEN NAME <b>VIRGINIA OLIVIA DEHRING</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>260X</b> DUE TO <b>Coma Diabeticum</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO <b>—</b> (c) DUE TO <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19</b> , to <b>19</b> , that I last saw the deceased alive on <b>19</b> , and that death occurred on <b>4:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Det W. Rieckert</b>		ADDRESS (Street, city or town, state) <b>4307 Mainfield Ave Baltimore 14 Md</b>	
PHYSICIAN'S NAME (Type) <b>Det W. Rieckert</b>		DATE <b>2-16-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>2-17-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		24a. REC'D BY REGISTRAR <b>FEB 19 '60</b>	
ADDRESS <b>5305 Harford Rd</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS 15 (4)  
ISM 9/58





## 1670 CERTIFICATE OF DEATH

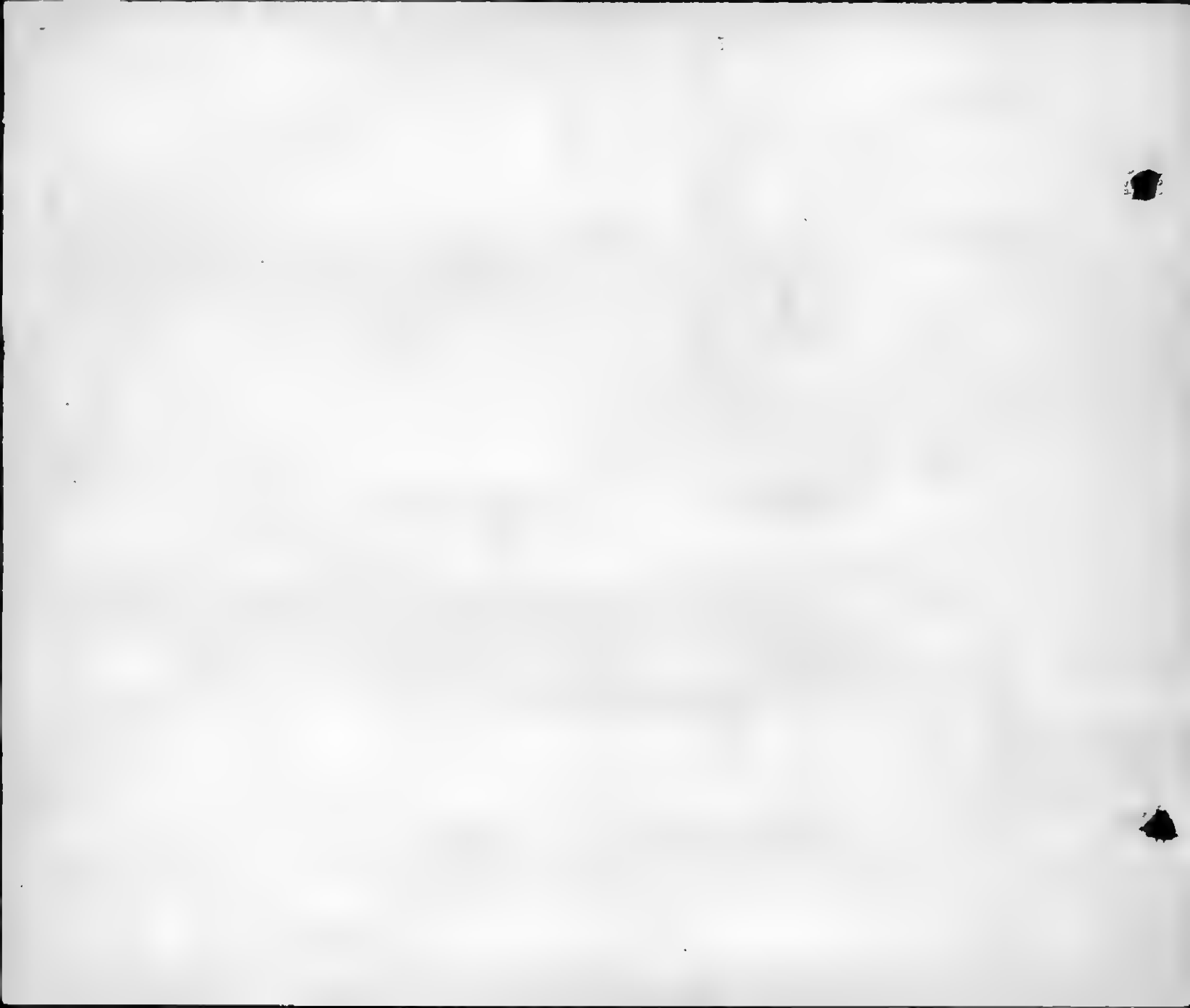
01654

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE-19</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>AS</b> b. COUNTY <b>IN</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WATERLOO POINT</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>IN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7000 N. POINT RD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>KAPLAN</b> Last <b>KAPLAN</b>		4. DATE OF DEATH Month <b>FEB</b> Day <b>6</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV 5, 1876</b>
9. AGE (In years last birthday) <b>83</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Morris Schwartz</b>		14. MOTHER'S MAIDEN NAME <b>Edith (maiden name unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>EDITH K. SMULSON</b>		Address <b>AS LW #1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Virus pneumonia</b> <b>492X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sensibility and Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 23, 1960</b> , to <b>FEB 6, 1960</b> , that I last saw the deceased alive on <b>FEB 5, 1960</b> , and that death occurred at <b>6 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6928 N. POINT RD</b> DATE SIGNED <b>2/6/60</b> ACTUAL SIGNATURE <b>Louis N. Tellin</b> M.D. PHYSICIAN'S NAME (Type) <b>LOUIS N. TELLIN, MD. Baltimore-19-7th</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>2-8-60</b>	<b>B'nai Abraham Hagerstown Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Kurzman</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 9 '60</b>	
ADDRESS <b>2100 Eutan Place</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



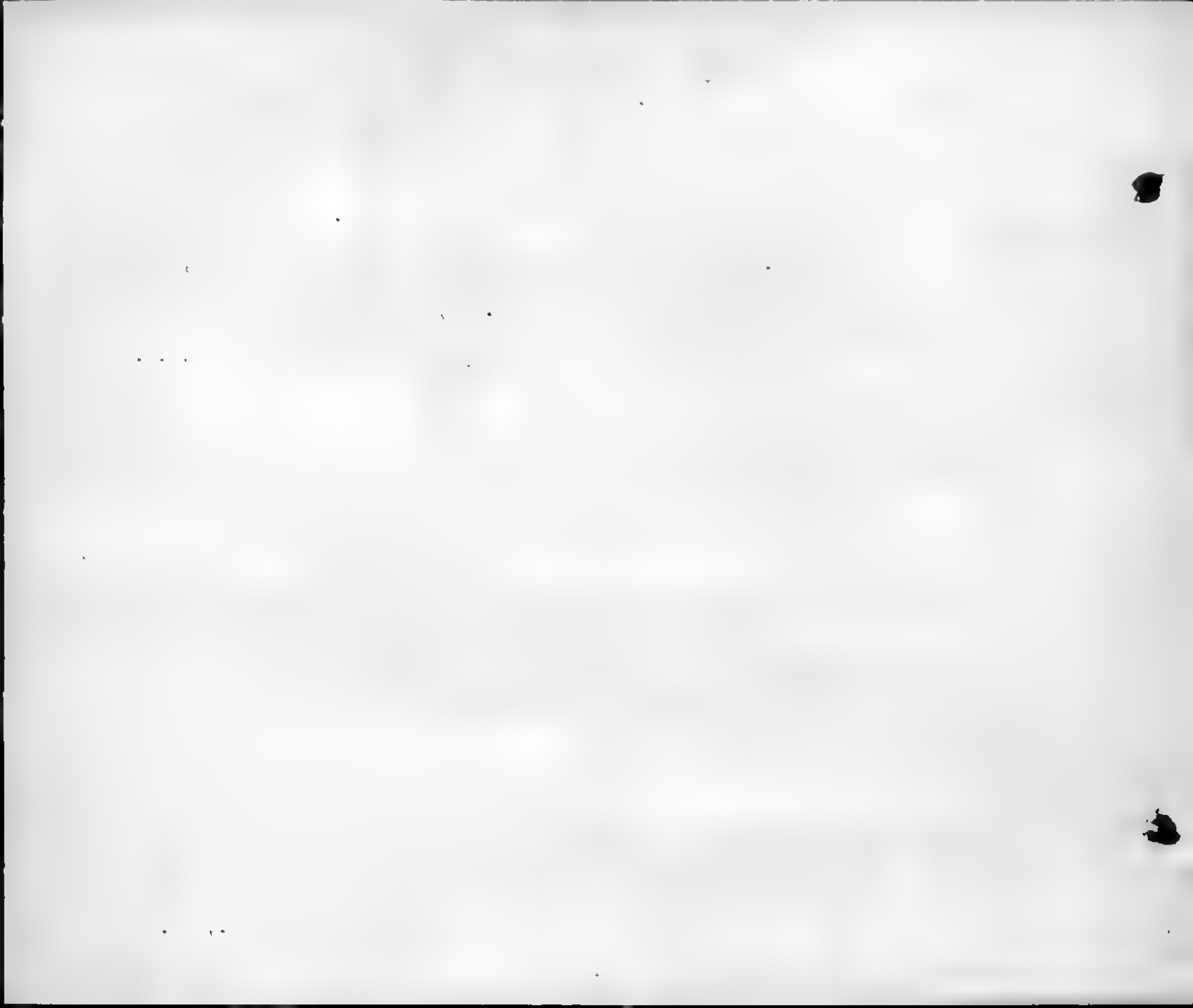
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE		Maryland		b. COUNTY		Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Essex (21)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		54 Essex (21)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1806 Elk Road		d. STREET ADDRESS		1806 Elk Rd.							
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day	
JOHN C. KEICHENMEISTER								February 14,				19 60	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Aug. 20, 1872		87 yrs.		Months		Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Plumber		Retired		Maryland		U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
UNKNOWN		UNKNOWN											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
NO		216-09-8359		Harry Keichenmeister		Same							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH		Sudden					
422.1 DUE TO		Arteriosclerotic Cardio Vascular		2 yrs									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO		disease									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
Hour a. m. p. m.		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>											
21. I certify that I attended the deceased from Jan 1, 1960, to Feb 14, 1960, that I last saw the deceased alive on Feb 14, 1960, and that death occurred at 10:30 P.M. from the causes and on the date stated above													
ACTUAL SIGNATURE		M. Baumgardner M.D.		Baltimore Md		DATE SIGNED		2/16/60					
PHYSICIAN'S NAME (Type)													
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)					
Burial		2/17/60		Moreland Memorial Park		Baltimore Co., Md.							
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE									
James Bruzdinski 2407 Eastern Ave.		DATE FEB 17 '60		C. L. H. H. H.									

**HOSPITAL CORONER ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



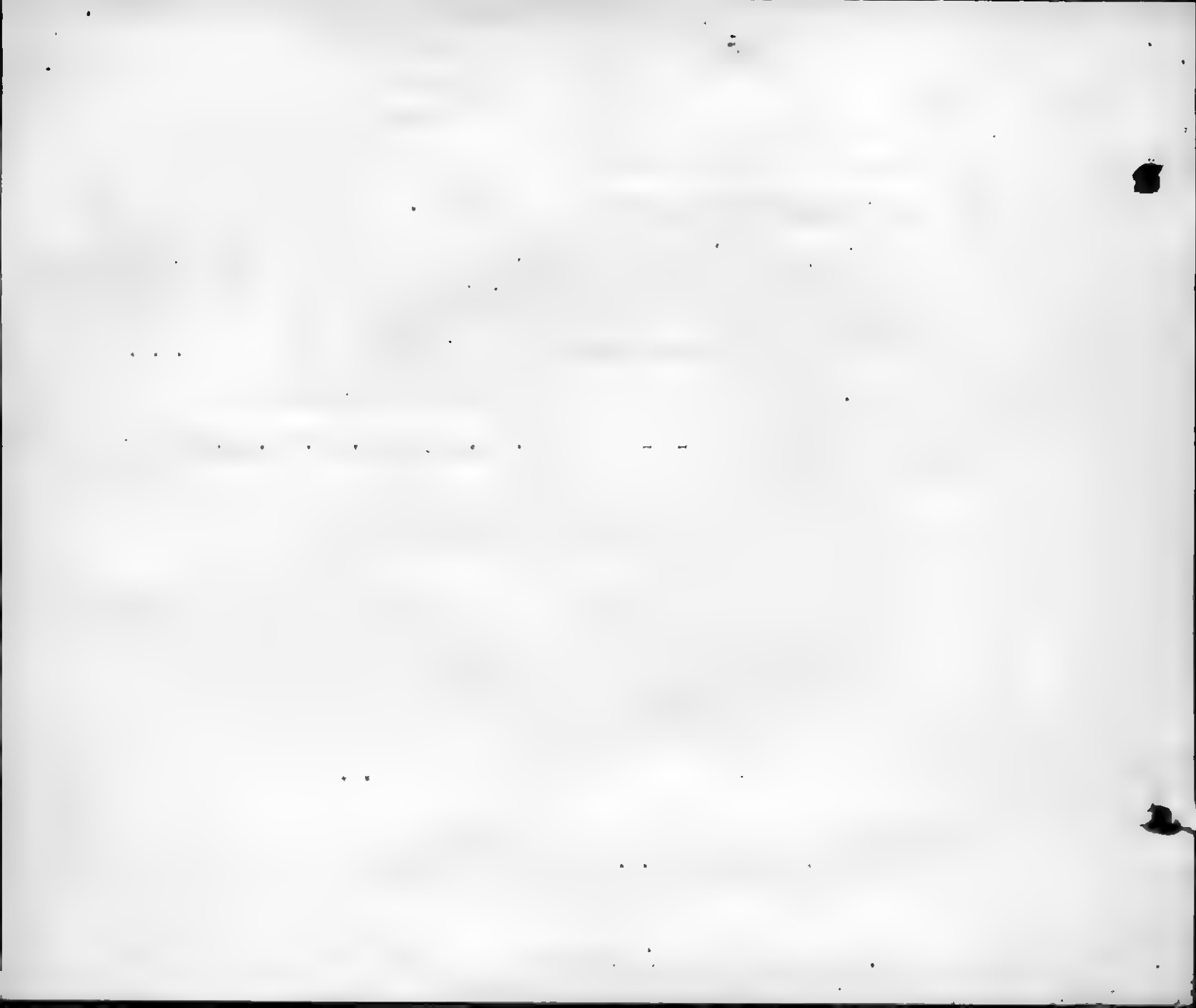
1672

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1672 CERTIFICATE OF DEATH

01656

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>3 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Harry W. Kellam</b> First Middle Last <b>Served As: Henry W. Kellam</b>		4. DATE OF DEATH Month <b>February</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/18/96</b>
9. AGE (In years last birthday) <b>63</b> yrs		10. IF UNDER 1 YEAR Months <b>63</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Packing House</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fred D. Kellam</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Bunting</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>217-05-9302</b>	
17. INFORMANT <b>WW I</b>		Address <b>Clin. Rec. V.A.H., Palto. Md. Ft. Howard Division</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>592x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CHRONIC GLOMERULONEPHRITIS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>1960</b> Hour <b>a. m.</b> p. m. <b>0</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>xx</b> (this hospital) attended the deceased from <b>February 10, 1960</b> to <b>February 13, 1960</b> , that <b>xx</b> (we) last saw the deceased alive on <b>February 13, 1960</b> , and that death occurred at <b>6:20 P.M.</b> on the causes and on the date stated above.			
22a. SIGNATURE <b>John E. Eisenlohr</b>		22b. DATE SIGNED <b>2/14/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN E. EISENLOHR, M.D.</b>		22d. ADDRESS <b>VAH, BALTIMORE, MD. FORT HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2/18/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 17 '60</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>



1673

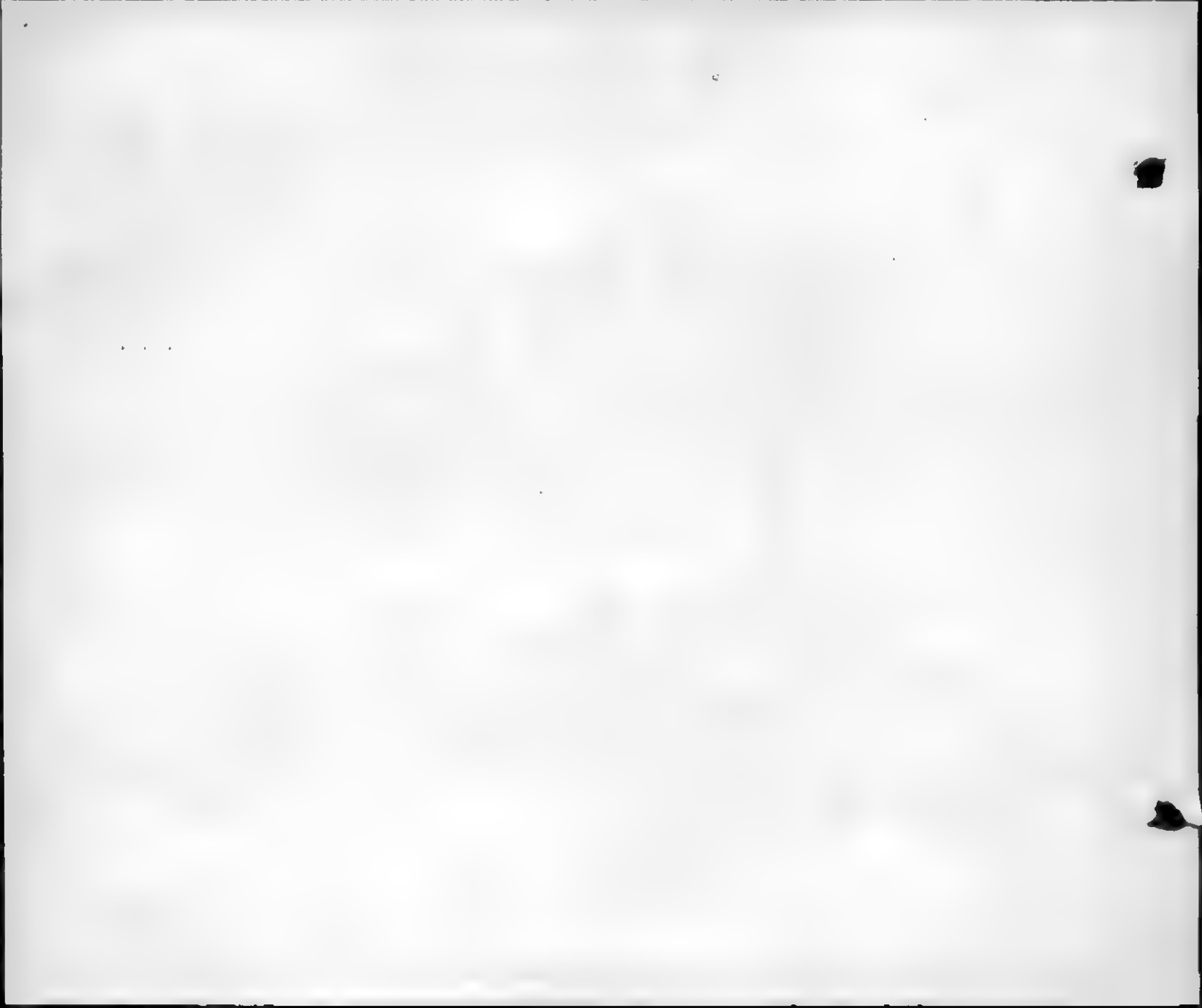
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Agnes Home for Aged Men &amp; Women</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Kendall, Miss May C Kendall</u>		4. DATE OF DEATH Month Day Year <u>Feb 23 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-16-67</u>
9. AGE (in years last birthday) yrs <u>93</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rep. in Congress</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Chestertown, Kent Co MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur Kendall</u>		14. MOTHER'S MAIDEN NAME <u>Laura Glenn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>41-14127 RN</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>acute leukemia</u>		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> to <u>February 23, 1960</u> , that I last saw the deceased alive on <u>February 21st, 1960</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Newland E. Day</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>4-E-3310 St Balto 18 Md Feb 22 1960</u>	
PHYSICIAN'S NAME (Type) <u>NEWLAND E. DAY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2-25-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chestertown Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Chestertown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc. 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 25 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1674

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines-16 Fusting Ave.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		f. STREET ADDRESS <b>Wilson &amp; Eutaw St</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		3Vo1-4	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARGARET LAUER KERNGOOD</b>		4. DATE OF DEATH Month Day Year <b>Feb. 5th, 1960</b>		5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Nov. 12th 1885</b>		9. AGE (In years last birthday) <b>74</b> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>John D. Lauer</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Welsh</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>-----</b>		16. SOCIAL SECURITY NO <b>-----</b>		17. INFORMANT Address <b>Mr. Louis F. Lauer-1507 Windemmer Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident.</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Malnutrition - marked anemia</b> DUE TO (c) <b>Cardiac Insuff.</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2-5-6</b> <b>Dec. 1959</b> <b>Dec. 1959</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Dec. 15, 1960</b> , to <b>Feb. 5, 1960</b> , that I last saw the deceased alive on <b>Feb. 4, 1960</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Dr. Bernard J. Cohen M.D. H. Maynard and</b>									
ACTUAL SIGNATURE <b>Dr. Bernard J. Cohen</b>		PHYSICIAN'S NAME (Type) <b>DR. BERNARD J. COHEN the Maynard and</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/9/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) <b>Balto., Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WIEDEFELD &amp; SON+ 501 E. 22nd Street</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 10 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Frank</b>			

MEDICAL CERTIFICATION

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

1675

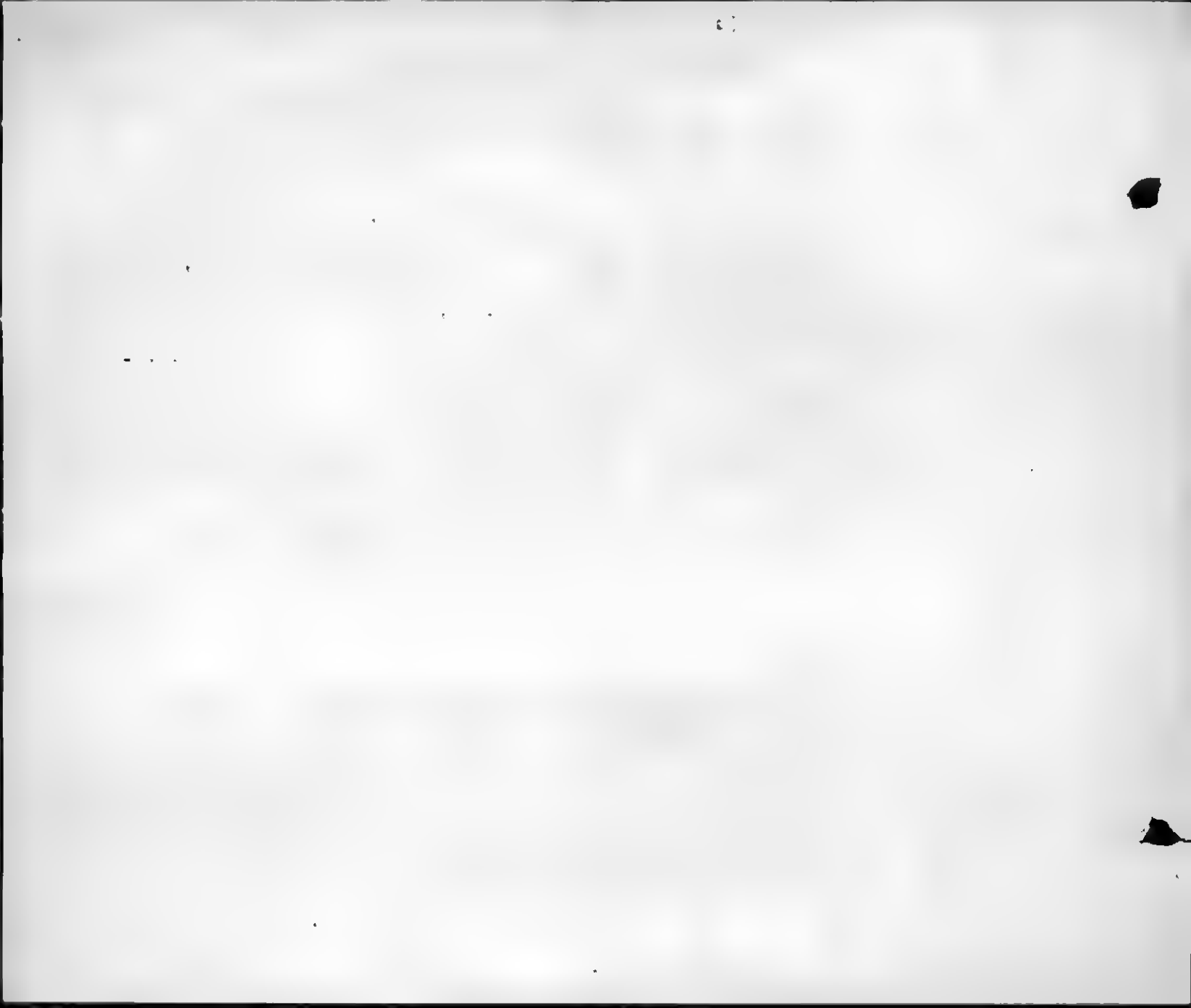
01659

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>		c. LENGTH OF STAY IN IB <b>54 Essex (21)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6 Avenal Road</b>		e. STREET ADDRESS <b>6 Avenal Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>AUGUSTA KOLBE</b>		4. DATE OF DEATH Month <b>February</b> Day <b>27</b> Year <b>19 60</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>Oct. 17, 1882</b>
9 AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Gardner</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Jubb</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Harry Kolbe</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> <b>46 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Thrombo-phlebitis, both legs</b> (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b> <b>1 mon</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arterio-sclerotic heart disease</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I attended the deceased from <b>April 27, 1948</b> , to <b>Feb 27, 1960</b> , that I last saw the deceased alive on <b>Feb 10, 1960</b> , and that death occurred at <b>8:50 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Joseph Niceli</b>		ADDRESS (Street, city or town, state) <b>108 S. Taylor Ave Baltimore 2, Md</b>	
PHYSICIAN'S NAME (Type) <b>JOSEPH NICELI M.D.</b>		DATE SIGNED <b>2/29/60</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/2/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Bruzdinski</b>		ADDRESS <b>1407 Eastern Ave.</b>	
24a. REC'D BY REGISTRAR <b>MAR 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Kline</b>	

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

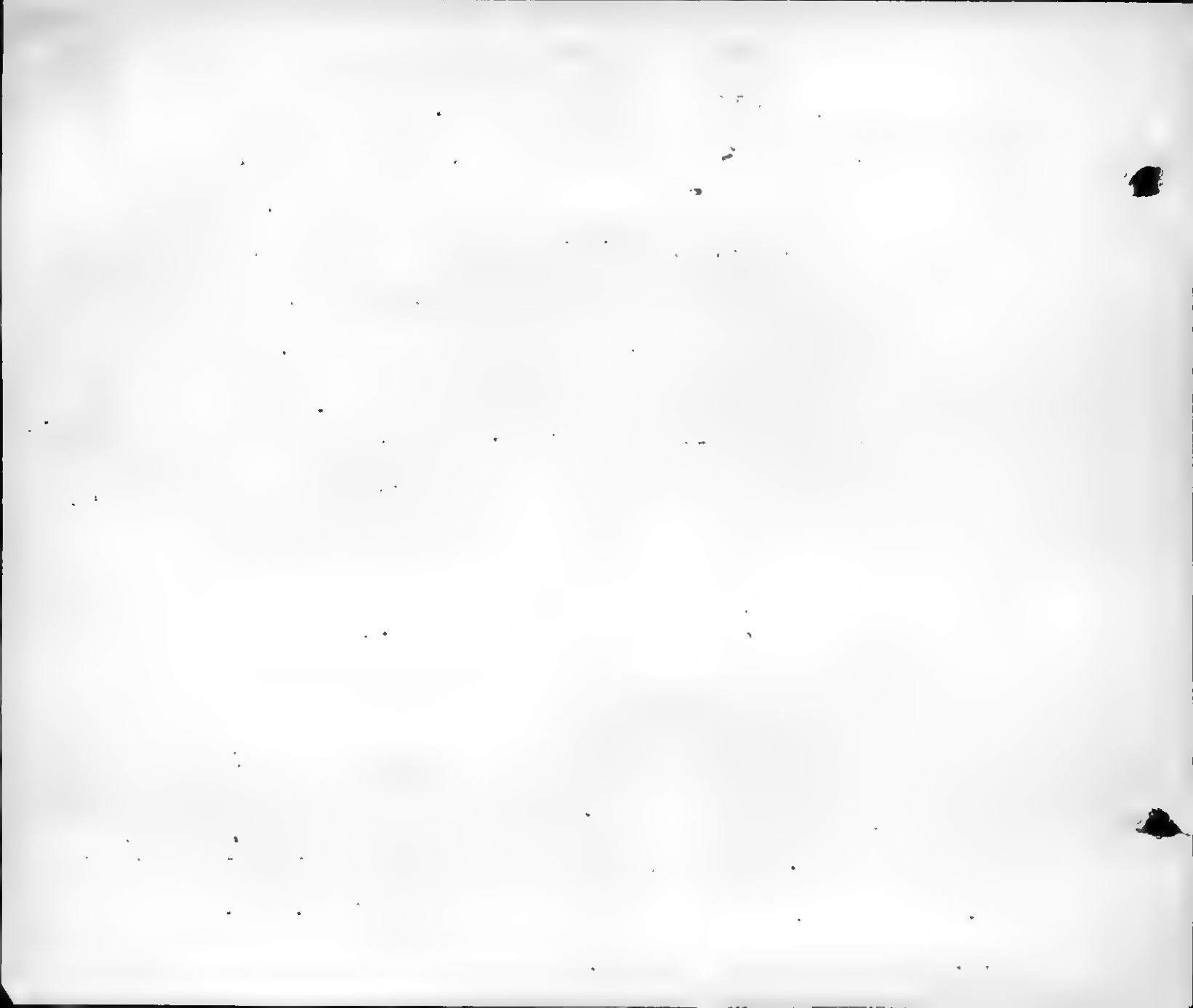
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1676

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Loseharn</b> c. LENGTH OF STAY IN 1b <b>5 Yrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Augsburg Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>7</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda Md. 17-57-2</b> d. STREET ADDRESS <b>5823 Bradley Blvd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>KATIE</b> First <b>M. E. KRIEGER</b> Middle <b>Last</b>		4. DATE OF DEATH <b>Feb. 8,</b> Month <b>1960</b> Day <b>19</b> Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28, 1875</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. UNDER 1 YEAR Months <b>Days</b>	11. UNDER 24 HRS. Hours <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Henry Krieger</b>	
14. MOTHER'S MAIDEN NAME <b>Katherine Lütner</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Records Augsburg Home</b> Address <b>Rd. 6811 Campfield</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>443x</b> IMMEDIATE CAUSE (a) <b>Hypertensive Heart Disease</b> DUE TO (b) <b>443x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>443x</b>			INTERVAL BETWEEN ONSET AND DEATH <b>53m.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arterio Sclerosis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Mar 19</b> , 19 <b>57</b> , to <b>Feb 8</b> , 19 <b>60</b> that I last saw the deceased alive on <b>Feb 4</b> , 19 <b>60</b> , and that death occurred at <b>1:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Earl L. Chambers</b> M.D.		ADDRESS (Street, city or town, state) <b>4108 Liberty Hts - Balto 7-Inf - 2-10-60</b> DATE SIGNED <b>Feb 12 '60</b>	
PHYSICIAN'S NAME (Type) <b>Earl L. Chambers</b>		4108 Liberty Hts - Balto - 9 Inf. -	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/11/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Immanuel Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.A. HEEMANN</b> ADDRESS <b>6067 HARFORD RD.</b>		24a. RECEIVED BY REGISTRAR <b>FEB 12 '60</b> DATE	24b. REGISTRAR'S SIGNATURE <b>i. S. Thomas</b>



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1677

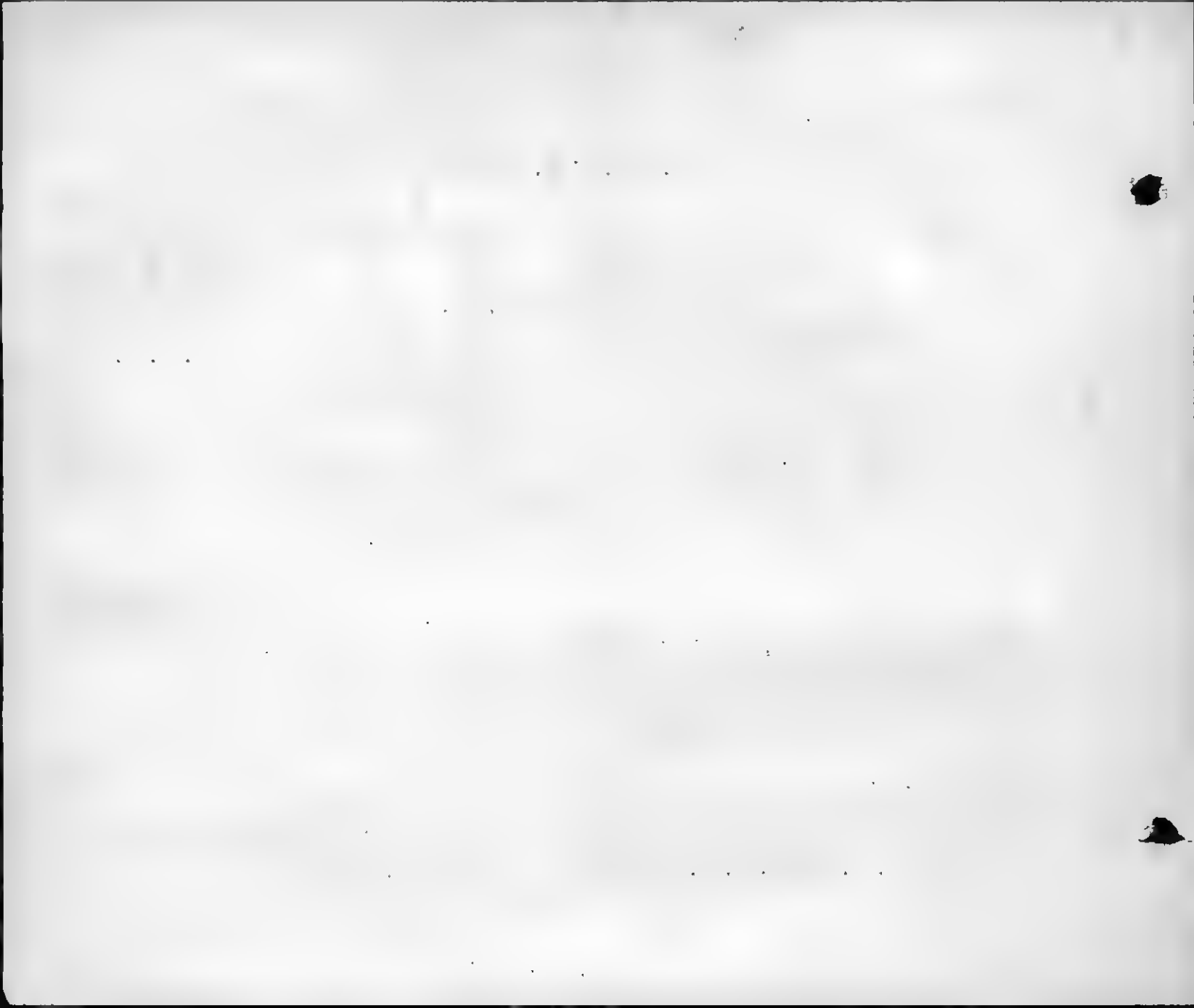
## CERTIFICATE OF DEATH

01661

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>1Yr. 3Mos. 21Das.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>THE SHEPPARD AND ENOCH PRATT HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Andrew</b> Middle <b>Hoffman</b> Last <b>Krug</b>		4. DATE OF DEATH Month <b>February</b> Day <b>1</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 29, 1882</b>
9. AGE (In years last birthday) yrs <b>77</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance Agent and Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Krug</b>		14. MOTHER'S MAIDEN NAME <b>Anna Shinnick</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>World War I Sev. Mos. in 1918</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 yr +</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mom's de pressure reaction, depressed type</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 10, 1958</b> to <b>Feb 1, 1960</b> , that I last saw the deceased alive on <b>Jan 30, 1960</b> , and that death occurred at <b>9:55 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>W. W. Elgin</b> M.D. <b>February 1, 1960</b> <b>Feb 1, 1960</b> The Sheppard and Enoch Pratt Hospital Towson 4, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2/3/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>WOODLAWN MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS INC. BALTO. MARYLAND</b>		24a. REC'D BY REGISTRAR <b>FEB 3 '60</b>	24b. REGISTRAR'S SIGNATURE <i>Wm. S. Thomas</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 1553 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7554 Battle Grove Circle</b>		d. STREET ADDRESS <b>7554 Battle Grove Circle</b>	
3. NAME OF DECEASED (Type or print) First <b>DAISY</b> Middle <b>MAY</b> Last <b>KYLE</b>		4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 20, 1884</b>
9. AGE (In years last birthday) yrs. <b>75</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>18</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Cole</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Plecher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. R. Pheleps, 3507 McShaneway, Dundalk</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>VIRUS PNEUMONIA</b> <b>480X</b> DUE TO <b>INFLUENZA</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>8 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>A-S-C-V Disease</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>No</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 1, 1960</b> to <b>Feb 4, 1960</b> , that I last saw the deceased alive on <b>Feb 4, 1960</b> , and that death occurred at <b>11:14 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Melvin B. Davis, M.D.</b>		ADDRESS (Street, city or town, state) <b>6800 Morningson Road</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Melvin B. Davis, M.D.</b>		<b>Baltimore 22, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/9/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter R. Bradley</b>		24a. REC'D BY REGISTRAR <b>Dundalk 22</b> DATE <b>FEB 8 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Pheleps</b>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01663

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institut on Residence before admision) a. STATE <u>md.</u> b. COUNTY <u>Balto. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. LENGTH OF STAY IN 1b <u>52</u> <u>Catonville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11 Paradise Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harold F. Lacey</u>		4. DATE OF DEATH <u>Feb. 11</u> 19 <u>60</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/11/01</u>
9. AGE (In years last birthday) <u>58</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>acct.</u>	
11. BIRTHPLACE (State or foreign country) <u>Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James C. Lacey</u>		14. MOTHER'S MAIDEN NAME <u>Clementine Kooken</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Mr. Catherine Lacey</u>	
17. INFORMANT <u>Mr. Catherine Lacey</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary thrombosis</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Geo. S. M. KIEFFER, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McGraft + Son</u> ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR <u>FEB 16 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Catherine L. Kieffer</u>		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01664

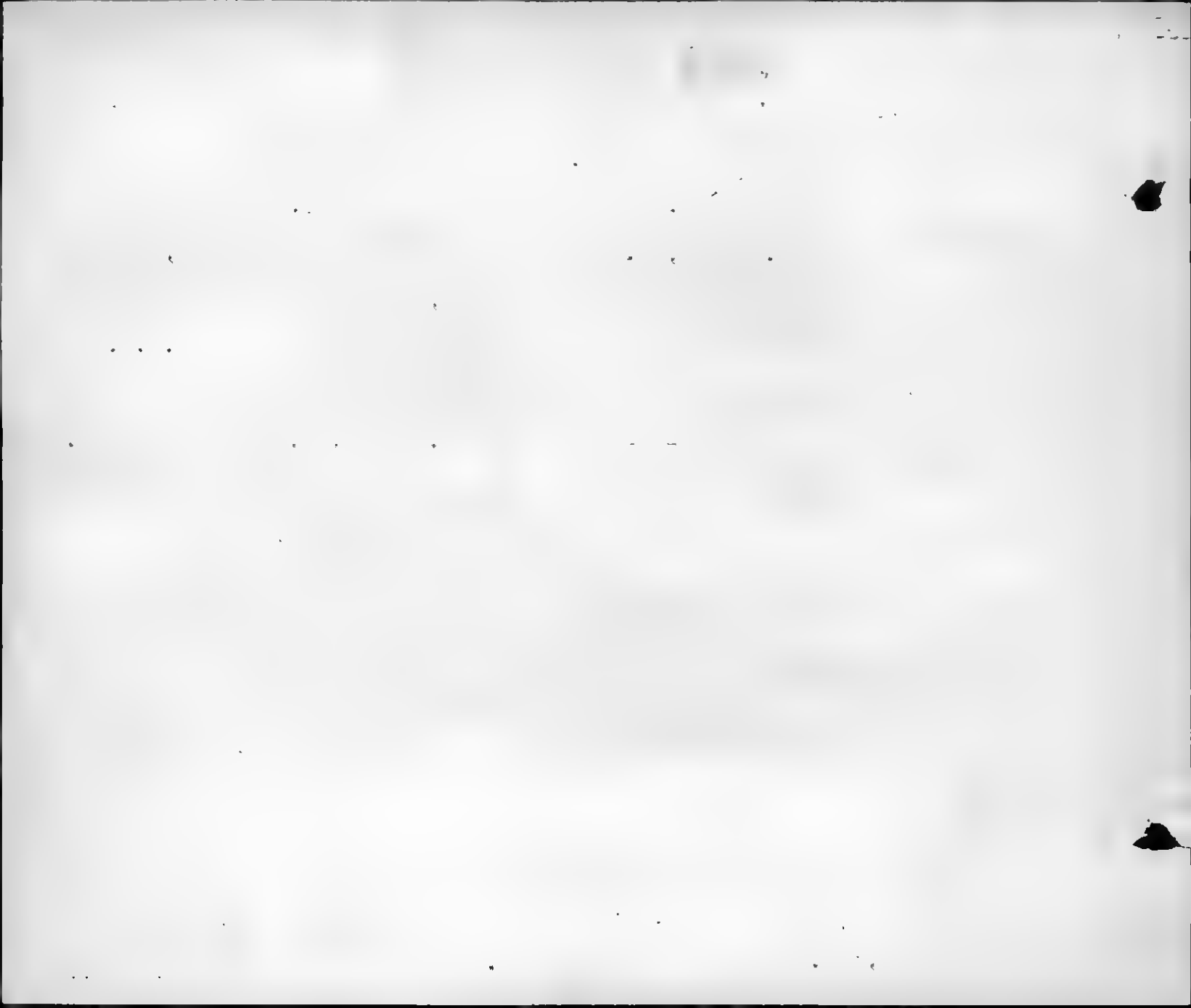
Reg. Dist. No.

1563

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>		c. LENGTH OF STAY IN 1b <b>18 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1319 Birch Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Homer S. Landes, Sr.</b> Middle Last		4. DATE OF DEATH Month <b>February</b> Day <b>7</b> Year <b>1960</b> 19	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 16, 1877</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Landes</b>		14. MOTHER'S MAIDEN NAME <b>Emma Knieely</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-20-7835</b>	
17. INFORMANT <b>Homer S. Landes, Jr.</b>		Address <b>1319 Birch Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Arteriosclerotic C. V. Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Smoking</b>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June</b> , 19 <b>56</b> , to <b>Feb. 7</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Feb. 5</b> , 19 <b>60</b> , and that death occurred at <b>8 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. Mac Laughlin</b>		ADDRESS (Street, city or town, state) <b>4508 Edmondson Village</b>	
PHYSICIAN'S NAME (Type) <b>2/7/60</b>		DATE SIGNED	
22a. BURIAL, CREMATON, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/10/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodbine Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Harrisonburg, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ambrose, Inc. 1328 Sulphur Spring Rd.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 8 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			

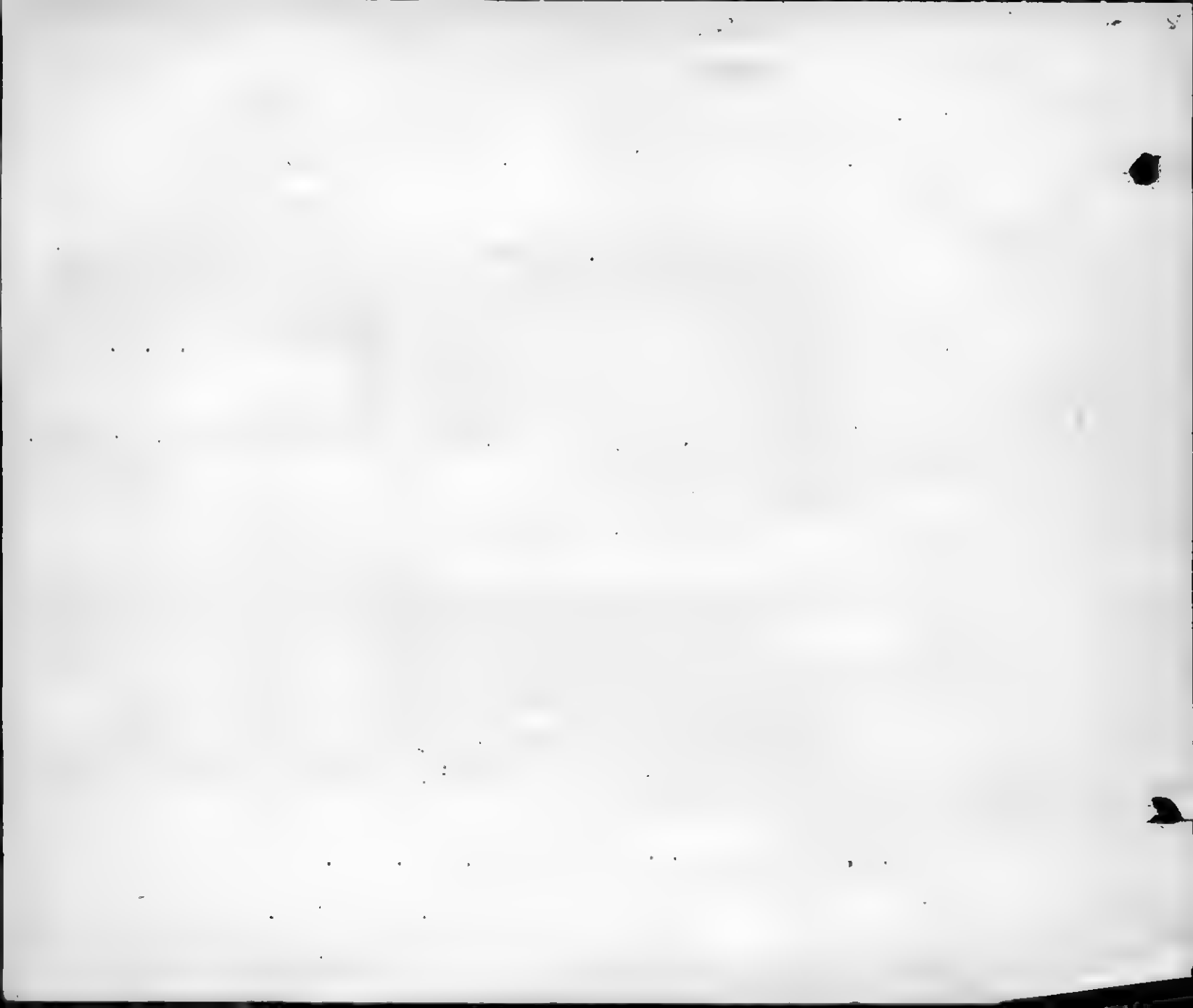
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL CERTIFICATION

VR A15 (4)  
- 9/59





# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 8,9 Film 256 2-11-60 et

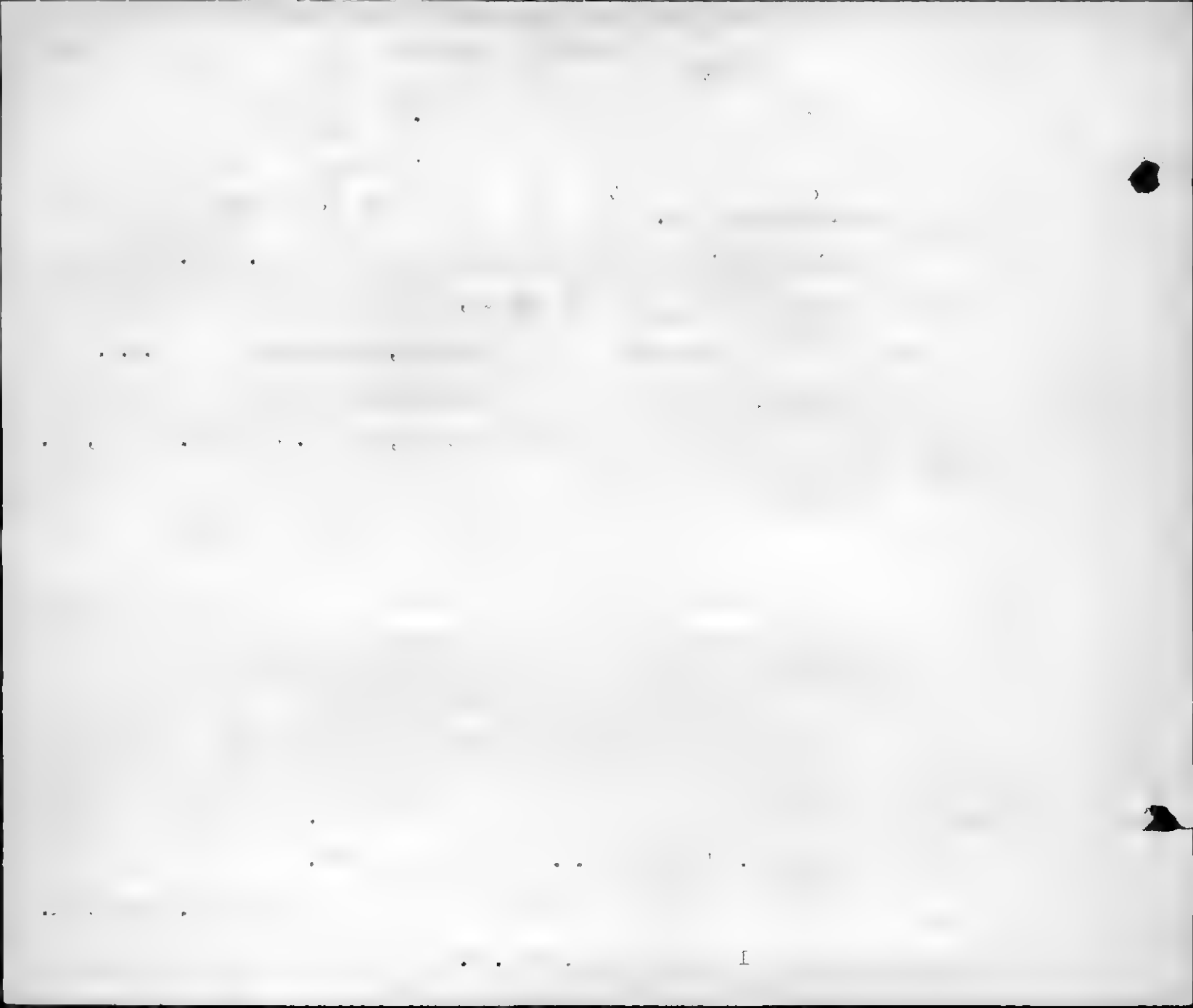
## CERTIFICATE OF DEATH

Reg. Dist. No.

01666

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>36 years</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm ssion) a. STATE <b>Md.</b>		b. COUNTY <b>C</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mission Helpers Convent</b> <b>1001 West Joppa Rd.</b>		e. STREET ADDRESS <b>1001 West Joppa Road</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Sister Mary Veronica (Lawlor)</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>1st.</b> Year <b>19 60</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>May 13, 1893</b>		9. AGE (In years last birthday) <b>66</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nun</b>		11. BIRTHPLACE (State or foreign country) <b>Broadcove, Newfondland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Timothy Lawlor</b>		14. MOTHER'S MAIDEN NAME <b>Mary Sheehan</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO (If yes, give year or dates of service) <b>none</b>		17. INFORMANT <b>Convent Records, 1001 W. Joppa Rd. Towson, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arterio-Sclerotic</b> DUE TO <b>10-yr</b> (c) <b>Vascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		21. I certify that I attended the deceased from <b>Oct. 19 46</b> to <b>February 19 60</b> that I last saw the deceased alive on <b>January 16 19 60</b> and that death occurred at <b>3:15 P.M.</b> from the causes and on the date stated above.		DATE SIGNED <b>2/12/60</b>	
ACTUAL SIGNATURE <b>Charles F. O'Donnell, M.D.</b>		ADDRESS (Street, city or town, state) <b>7501 York Road.</b>		PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>		ADDRESS <b>7501 York Road.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/4/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Convent Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>1001 West Joppa Rd. Towson, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. Vernon Lemmon</b>		ADDRESS <b>4611 Park Heights, Balto. Md.</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 3 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1681

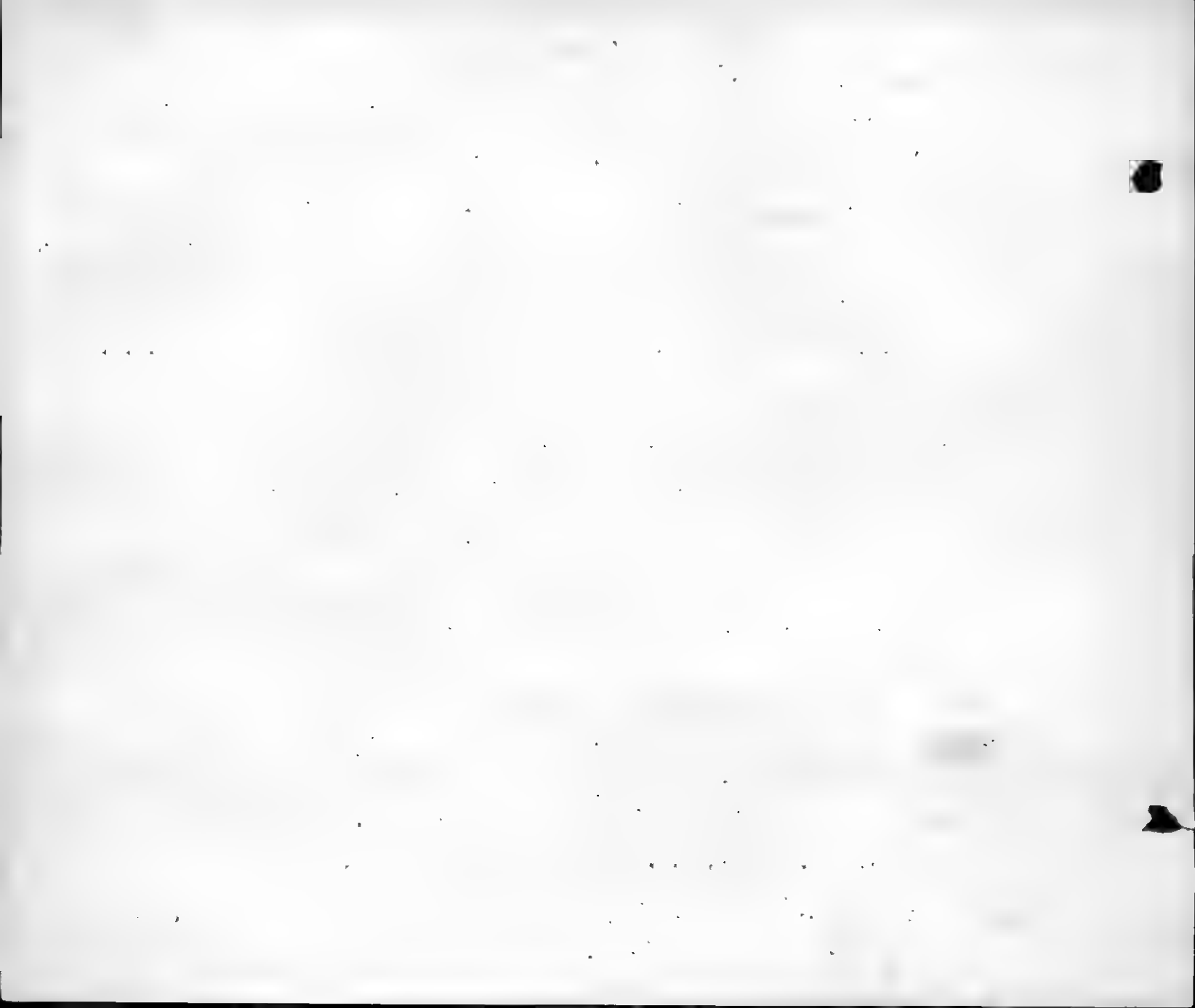
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u> c. LENGTH OF STAY IN 1b <u>2 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen, Maryland</u> d. STREET ADDRESS <u>312 F. East Court Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Pamela</u> Middle <u>Jean</u> Last <u>Lervig</u>		4 DATE OF DEATH Month <u>2</u> Day <u>4</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/7/57</u>
9. AGE (In years last birthday) <u>2</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>4</u>	IF UNDER 24 HRS Hours <u>19</u> Min <u>60</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Roger Junior Lervig</u>	
14. MOTHER'S MAIDEN NAME <u>Bonnie Ziegenbein</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>no</u>		INFORMANT <u>Rosewood Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition and multiple decubiti ulcers - scalp</u> <u>500x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Acute bronchitis and broncho pneumonia</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenital hydrocephalus - type not determined - since birth</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>1 day</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>4/25/57</u> , 19____, to <u>2/4/60</u> , 19____, that I last saw the deceased alive on <u>2/4/60</u> , 19____, and that death occurred at <u>11:30am</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry G. Butler</u> M.D.		ADDRESS (Street, city or town, state) <u>Rosewood St. Training School</u> DATE SIGNED <u>2/4/60</u>	
PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u>		<u>Owings Mills, Maryland</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Buried Feb. 5, 1960</u>	22b. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>	22c. LOCATION (City, town, or county) <u>Baltimore, Md.</u>	(State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank D. Howell</u>		24a. REC'D BY REGISTRAR <u>FEB 11 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



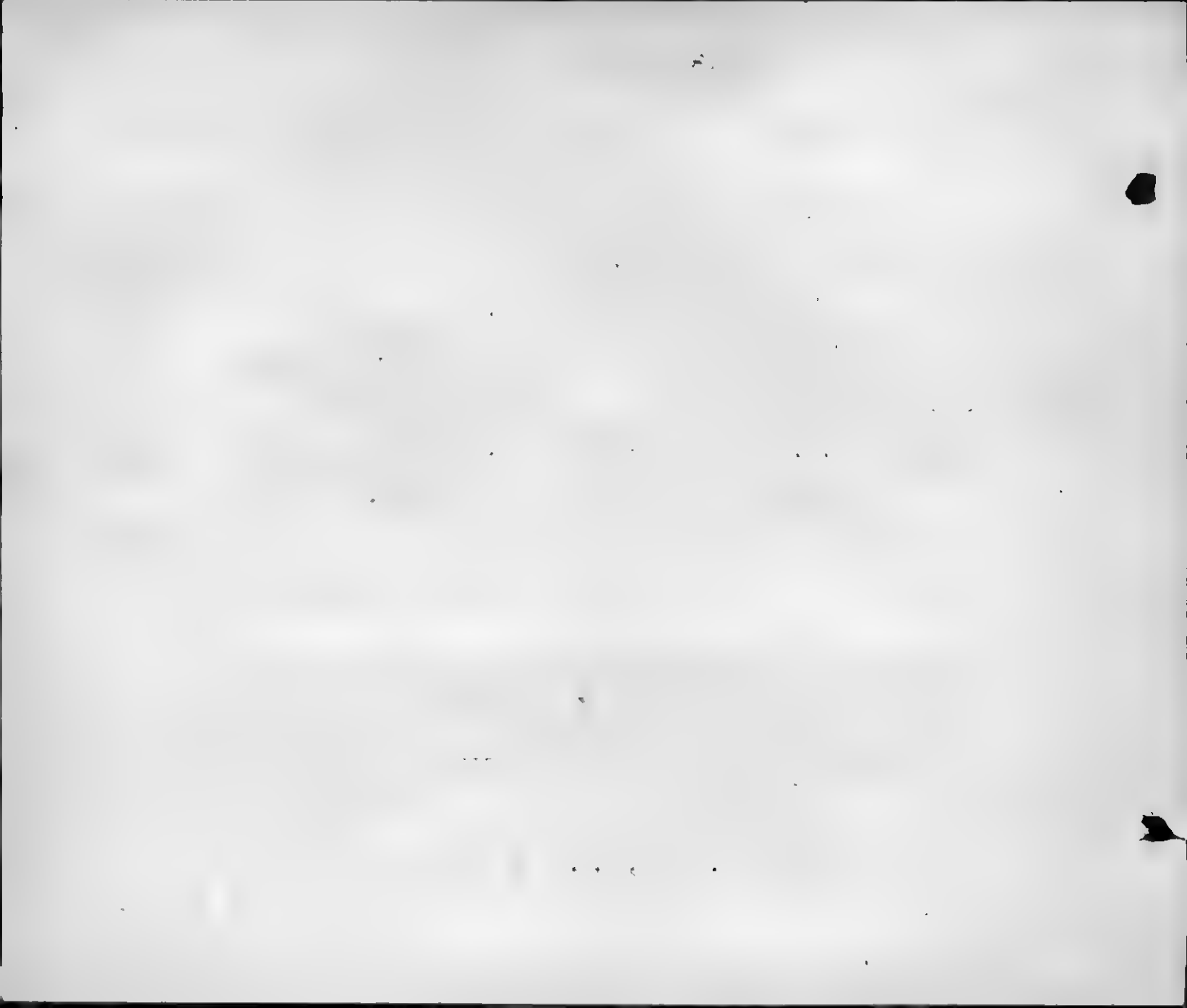
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1 ~~X~~  
FOR STATE  
HEALTH DEPT.

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		a. STATE		b. COUNTY	
Baltimore		Baltimore		Maryland		Baltimore	
c. LENGTH OF STAY (in days)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
				Parkville			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
8615 Oakleigh Road				8615 Oakleigh Road			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
Casimir (CASINNI) L. LEWANDOWSKI				February 6 1960			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Mar. 4, 1921	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
Clerk, Social Security				Baltimore, Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Stanislaus Lewandowski				Mary Sokolowski			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT			
Yes W.W.2 213-12-2287				Mrs. Evelyn Lewandowski, same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO				Arteriosclerotic Heart Disease.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I's				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Charles S. Petty, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/9/60			
22c. NAME OF CEMETERY OR CREMATORY Baltimore National				22d. LOCATION (City, town, or country) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE			
Leonard J. Ruck 5305 Harford Road #14				DATE FEB 9 '60 Arthur S. Fenn			



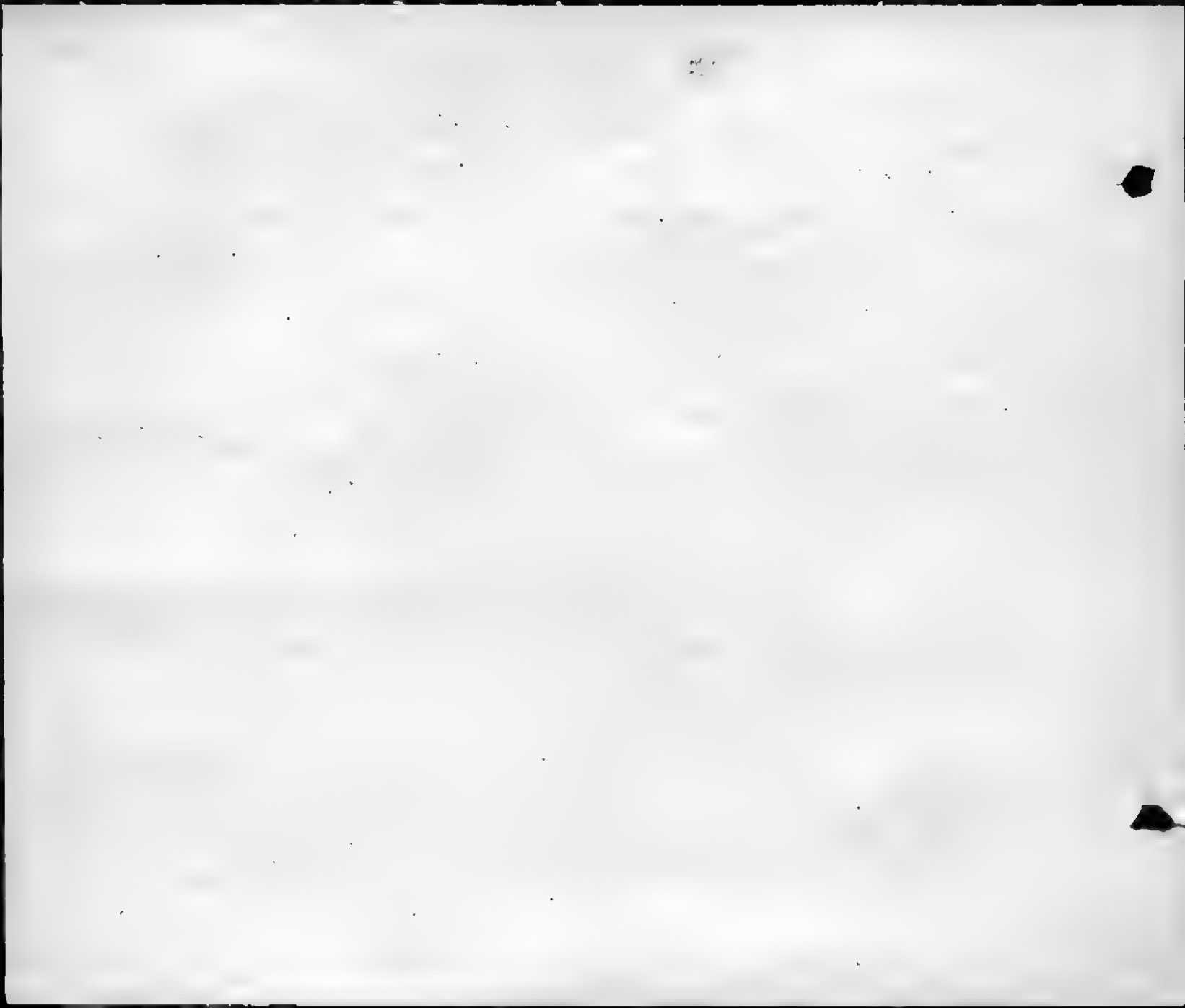
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
1683 CERTIFICATE OF DEATH

01669

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City - (Rural)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Steady Nook Home</u>				e. STREET ADDRESS <u>53 Eversgreen Ave. Oakview Estates</u>			
3. NAME OF DECEASED (Type or print) <u>Anton Lueke</u>				4. DATE OF DEATH <u>February 1 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-22-1925</u>	9. AGE (In years last birthday) <u>34</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Burr R.P.</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Frank O Lueke</u>				14. MOTHER'S MAIDEN NAME <u>Mary Carleton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Thelma Wilson - Ellicott City, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Heart Failure</u> (c) <u>Cardio. Vascular-Renal Disease</u>				INTERVAL BETWEEN ONSET OF DEATH <u>3 1/2 weeks</u> <u>3 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1.19.56</u> to <u>1.31.60</u> , that (I) (we) last saw the deceased alive on <u>1.3.60</u> and that death occurred on <u>Feb 1</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>George E. Urban</u>				22b. DATE SIGNED <u>2.1.60</u>		22c. PHYSICIAN'S NAME (Type) <u>George E. URBAN</u>	
22d. ADDRESS <u>805 2nd Ave</u>				22e. CITY <u>Baltimore</u>		22f. STATE <u>Md.</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2-4-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>London Park Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Baltimore</u>				23e. (State) <u>Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mundraft &amp; Son</u>				25a. REC'D BY REGISTRAR <u>FEB 5 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01670

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>V</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Armcast Nursing Home</b>		d. STREET ADDRESS <b>4 E. Eager St.</b>	
3. NAME OF DECEASED (Type or print) First <b>LILLIE</b> Middle <b>LYONS</b> Last <b>LYONS</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>25,</b> Year <b>19 60</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 1, 1869</b>
9. AGE (In years last birthday) <b>90 yrs.</b>		IF UNDER 1 YEAR Months <b>90</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	11. BIRTHPLACE (State or foreign country) <b>Ohio</b>
12. CITIZEN OF WHAT COUNTRY? <b>US</b>			
13. FATHER'S NAME <b>Christopher C. Ballard</b>		14. MOTHER'S MAIDEN NAME <b>Mary Baker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Miss Hazel Lyons</b>		Address <b>4 E. Eager St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hy. Pneumonia</b> DUE TO <b>Fractured Hip</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fractured Hip</b> DUE TO (c) <b>Fractured Hip</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b> <b>3 Weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell over rug in own home.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>Jan. 7 19 60</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Baltimore City Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>2/27/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Crem.</b>
		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mr. J. S. S. S. S.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 29 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Charles E. S. S.</b>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



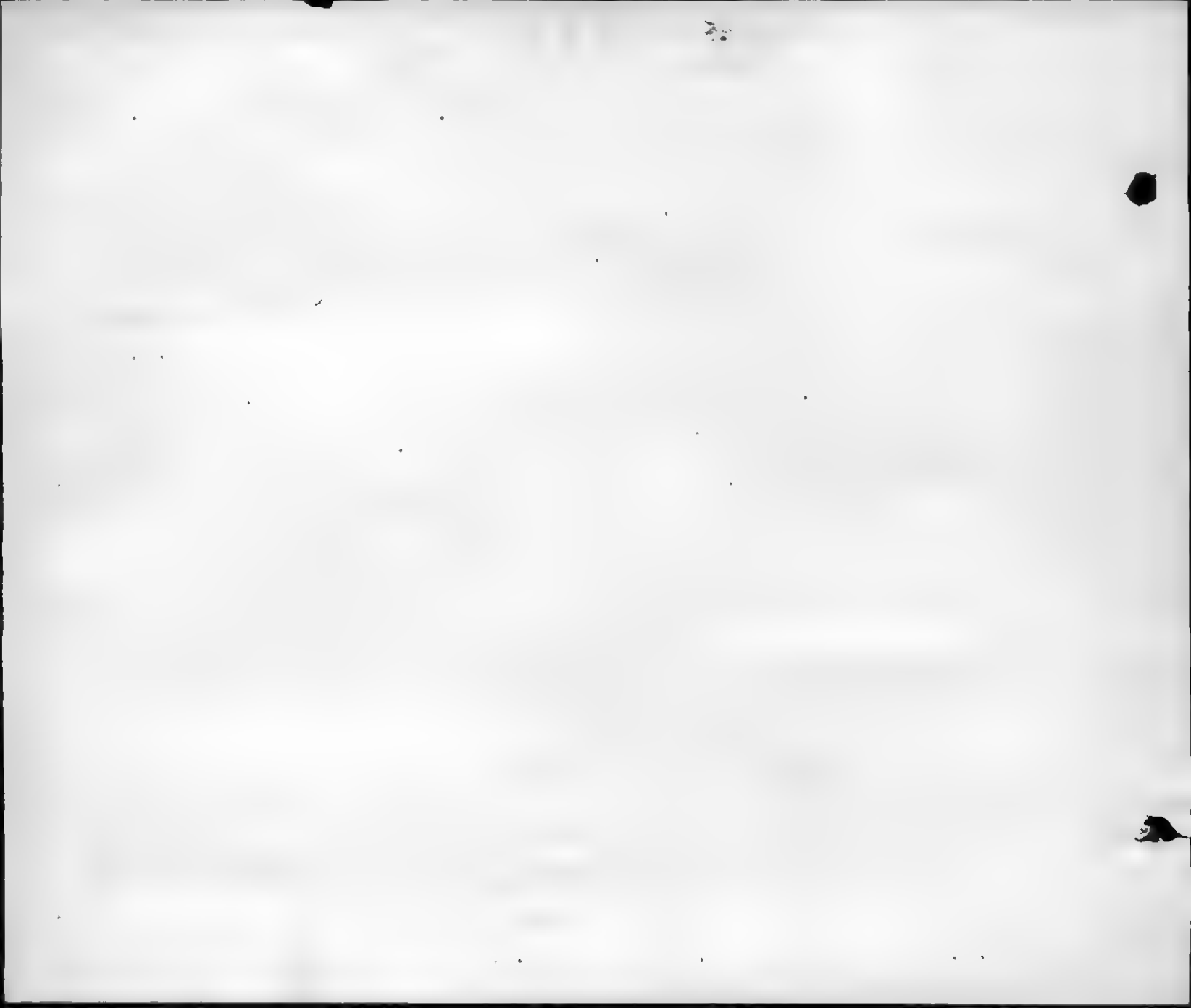
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01671

**1685 CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u> Md. </u> b. COUNTY <u> Balto. </u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u> Baltimore 12 </u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>127 Stanmore Rd.</u>				d. STREET ADDRESS <u>127 Stanmore Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>S.</u> Last <u>MacDonald</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>22</u> Year <u>1960</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 24, 1900</u>		9 AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B&amp;O RR</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Edward G. MacDonald</u>				14. MOTHER'S MAIDEN NAME <u>Cordelia Sprinkle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>----</u>			
17. INFORMANT <u>Elizabeth C. MacDonald</u>				Address <u>Above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lung</u> <u>181.0</u> DUE TO <u>1 year</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>1 year</u> DUE TO <u>metastasis</u>							
(c) <u>metastasis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
				20f. (City or town) <u>  </u>		(County) <u>  </u> (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>  </u> 19 <u>  </u> to <u>  </u> 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>  </u> 19 <u>  </u> , and that death occurred at <u>  </u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>  </u> M.D.				22b. DATE SIGNED <u>  </u>			
22c. PHYSICIAN'S NAME (Type) <u>  </u>				22d. ADDRESS <u>  </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-26-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Jenkins &amp; Sons Co.</u>				ADDRESS <u>4905 York Rd., 12</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 24 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Than please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

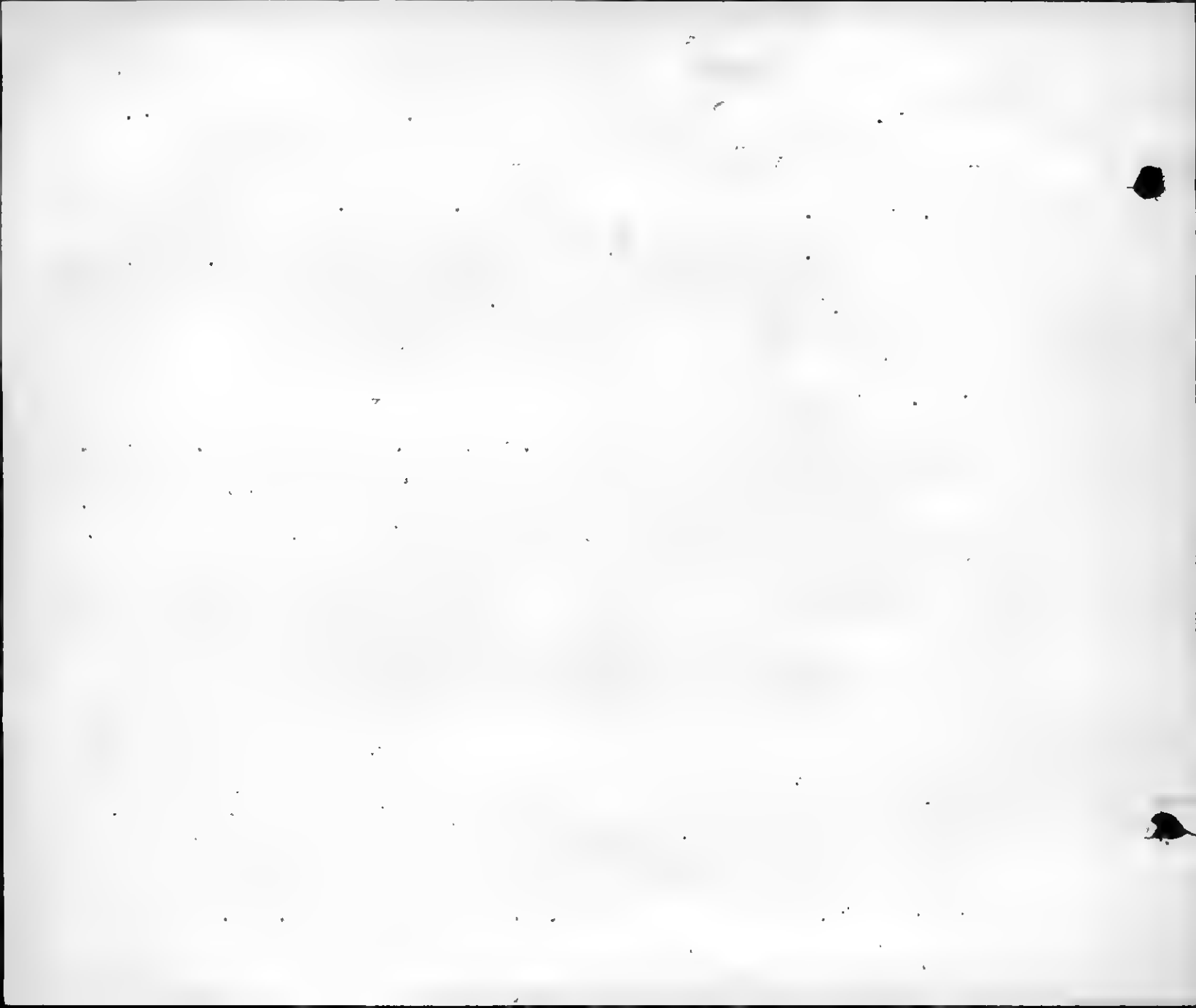
Reg. Dist. No.

1685

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1830 E. Joppa Rd.</b>		d. STREET ADDRESS <b>1830 E. Joppa Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>D.</b> Middle <b>LOWELL</b> Last <b>MADDEN</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>7.</b> Year <b>19 60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 12, 1903</b>
9. AGE (In years last birthday) <b>56</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Heating</b>	11. BIRTHPLACE (State or foreign country) <b>Michigan</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Henry B. Madden</b>	
14. MOTHER'S MAIDEN NAME <b>Mary -</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO.		INFORMANT Address <b>Mrs. Mildred C. Madden - 1830 E. Joppa Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction old + new</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Art. CV Dis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs</b> <b>12 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July</b> , 19 <b>48</b> , to <b>July</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>February 2</b> , 19 <b>60</b> , and that death occurred at <b>12:50 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Lester A. Wall Jr</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>2/8/60</b>	
PHYSICIAN'S NAME (Type) <b>LESTER A WALL JR</b>		M.D. <b>1039 St Vaux St</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/10/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wm. J. Dickener &amp; Sons - Balt 017 Md</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 9 '60</b>	24b. REGISTRAR'S SIGNATURE <b>James S. Thomas</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



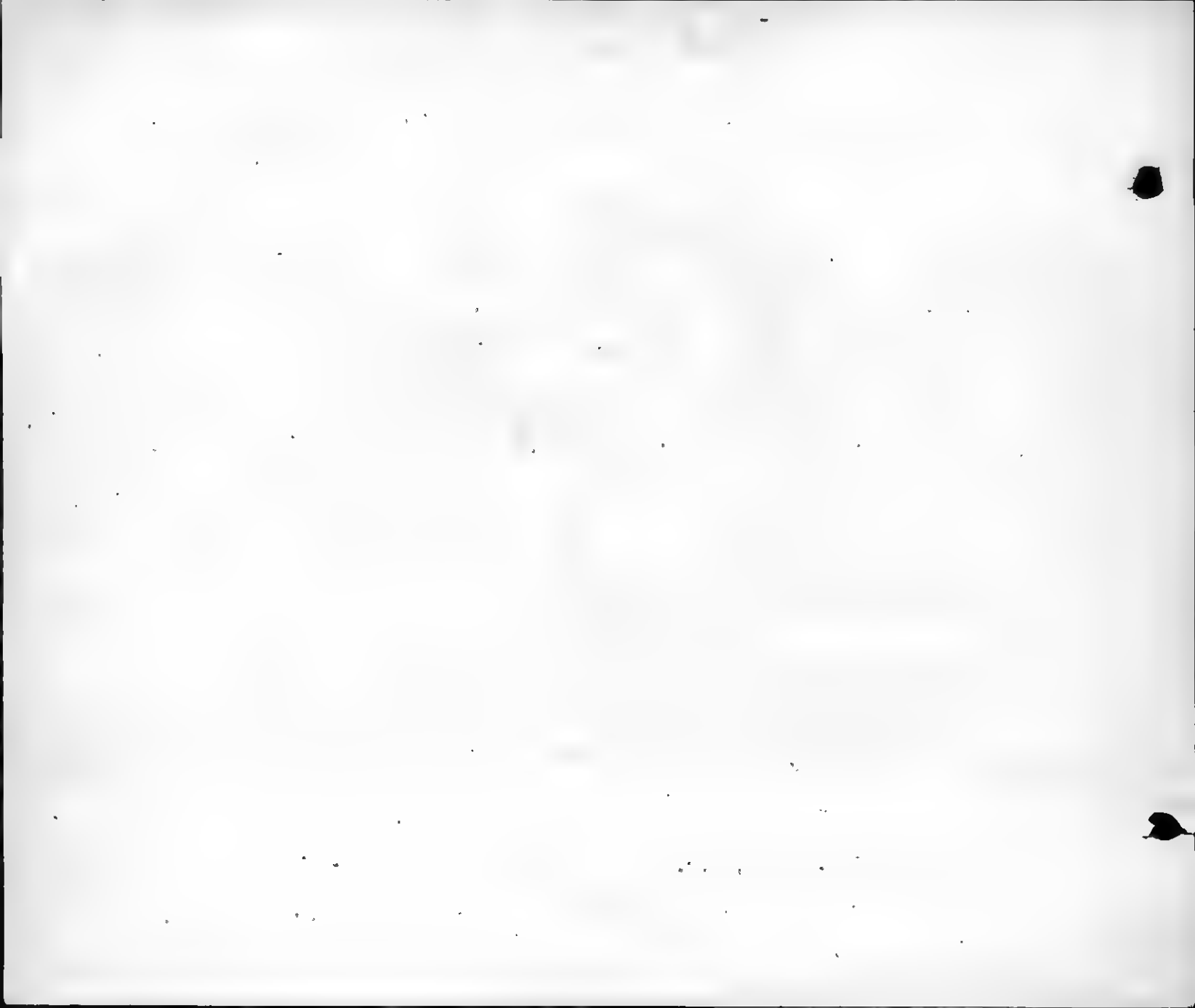
**MEDICAL CERTIFICATION**

VS A15 (4)  
15M 10/57









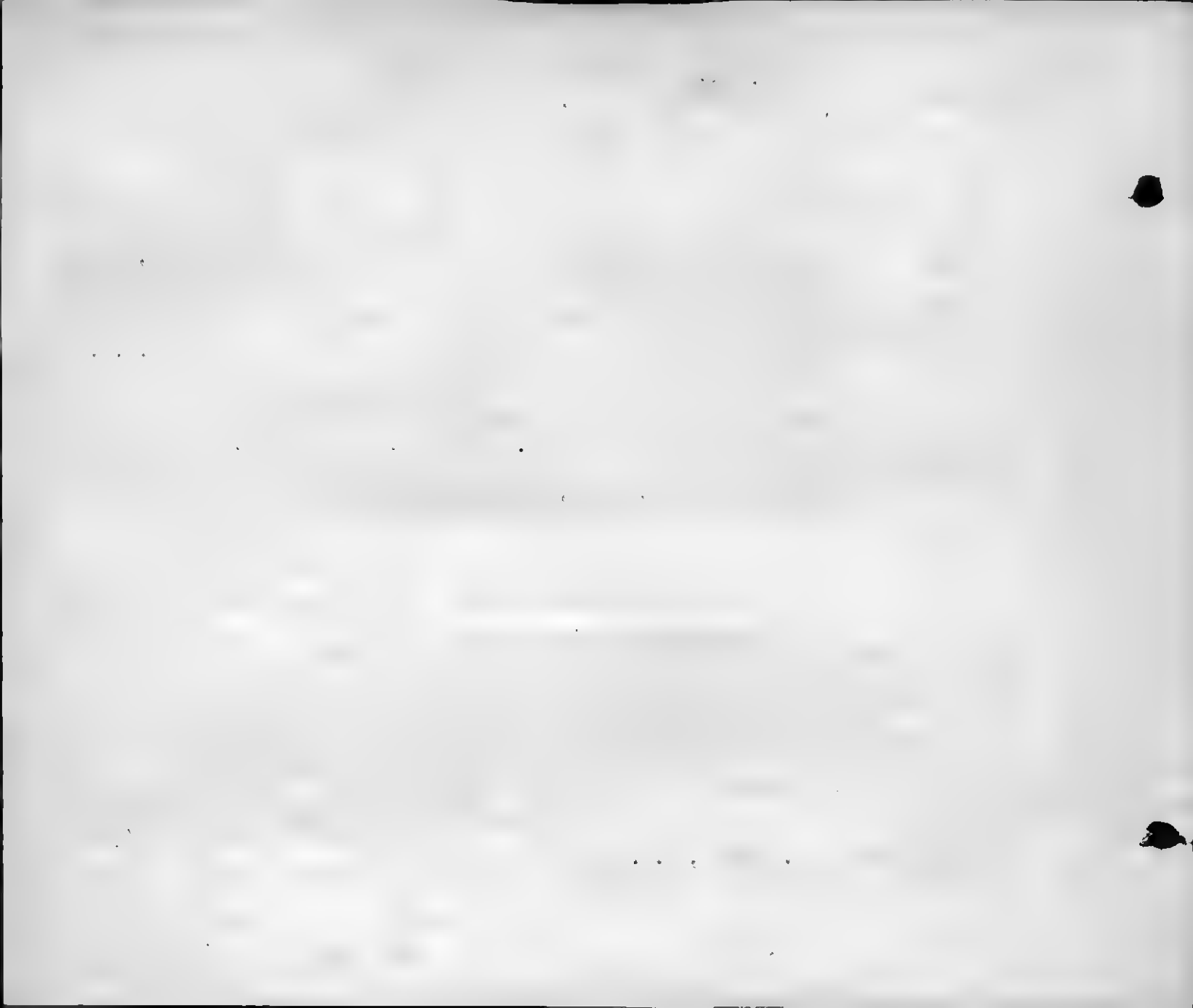
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

1  
FOR STATE  
HEALTH DEPT.

1675  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		1689		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 4</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Towson 4</b>		d. STREET ADDRESS <b>330 Aigburth Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>330 Aigburth Road</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ETHEL</b>		First		Middle <b>GERALDINE</b>		Last <b>MARSHALL</b>	
4. DATE OF DEATH <b>February 14, 1960</b>		Month		Day		Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 5, 1904</b>	
9. AGE (In years last birthday) <b>55</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Murray</b>		14. MOTHER'S MAIDEN NAME <b>Ethel Lee Zackerway</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Wm.H. Marshall, 330 Aigburth Road, Towson</b>	
17. INFORMANT <b>Wm.H. Marshall, 330 Aigburth Road, Towson</b>		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilaterally</b> <b>441 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fatty degeneration of liver</b> 2Db. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) DATE SIGNED <b>2/15/60</b>		ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> EXAMINER'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>2-17-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore</b>		24a. REC'D BY REGISTRAR <b>FEB 16 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>	
23. FUNERAL DIRECTOR <b>Wm. Cook-Towson, Inc., 1050 York Road, Towson</b>		ADDRESS					



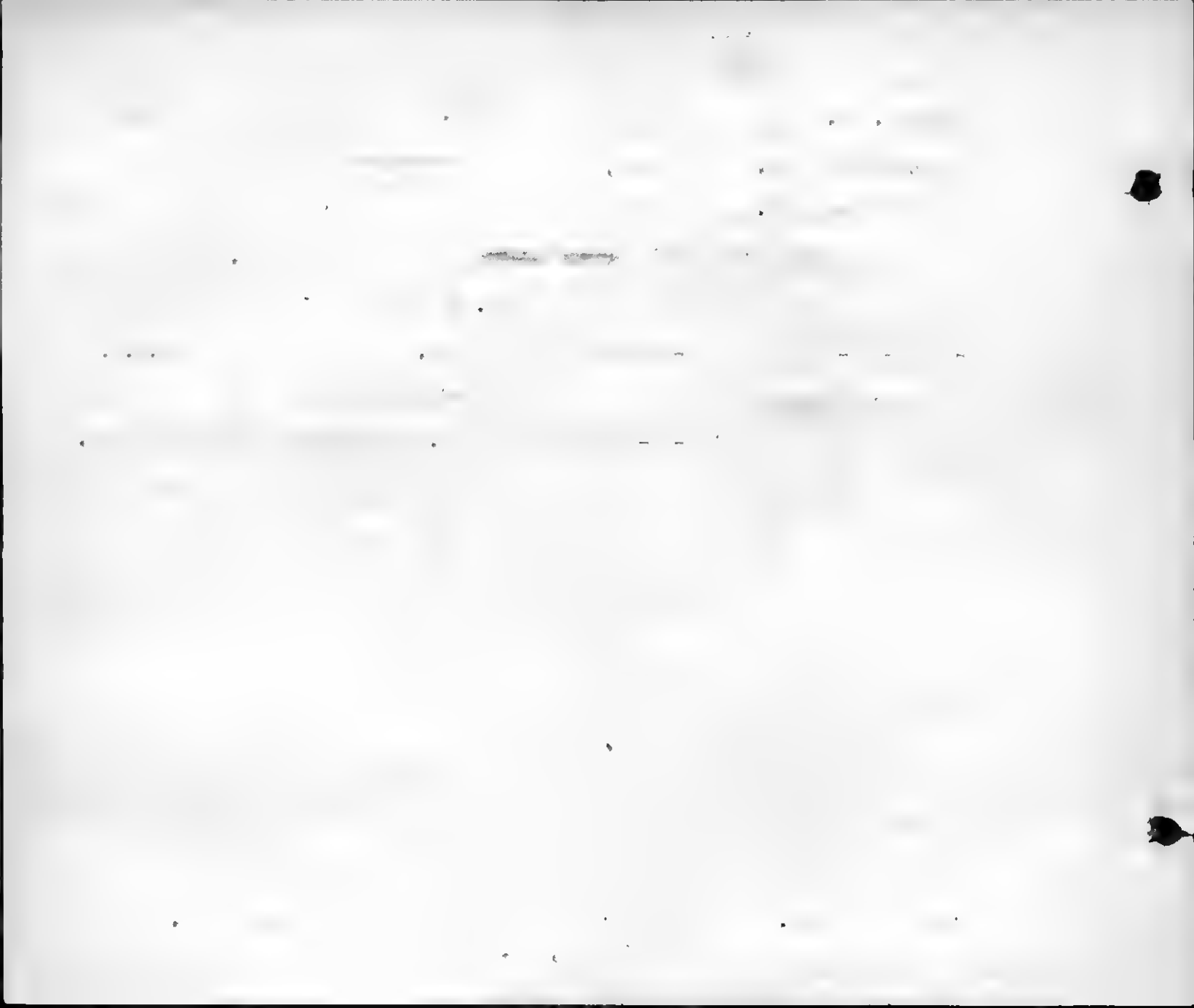
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto. Co.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Carroll</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cedarhurst</b>	
c. LENGTH OF STAY IN 1b <b>3 wks.</b>		d. STREET ADDRESS <b>none</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>204 McHenry St.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Barbara Marie Martin (nee Brown)</b>		4. DATE OF DEATH Month Day Year <b>Feb. 9th 19 60</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 20 1888</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Brown</b>		14. MOTHER'S MAIDEN NAME <b>Mary Stein</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>** **</b>		16. SOCIAL SECURITY NO. <b>215-36-8329</b>	
17. INFORMANT Address <b>Daughter Mrs. Ethel Mathews Pikesville Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Decompensation</b> <b>443X</b> DUE TO <b>Hypertension + arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>hypostatic pneumonia</b> (c) <b>2 weeks</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-15-60</b> to <b>2-9-60</b> , that I last saw the deceased alive on <b>2-9-60</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Westminster Md.</b> DATE SIGNED <b>2-10-60</b>			
ACTUAL SIGNATURE <b>James G. Saffell</b>		M.D. <b>Reisterstown Md.</b>	
PHYSICIAN'S NAME (Type) <b>James G. Saffell</b>		<b>Reisterstown Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 11 60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Leisters Church Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Carrollton Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Saffell Jr.</b>		24a. REG. BY REGISTRAR <b>ED 12 60</b>	24b. REGISTRAR'S SIGNATURE <b>CH 18 60</b>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

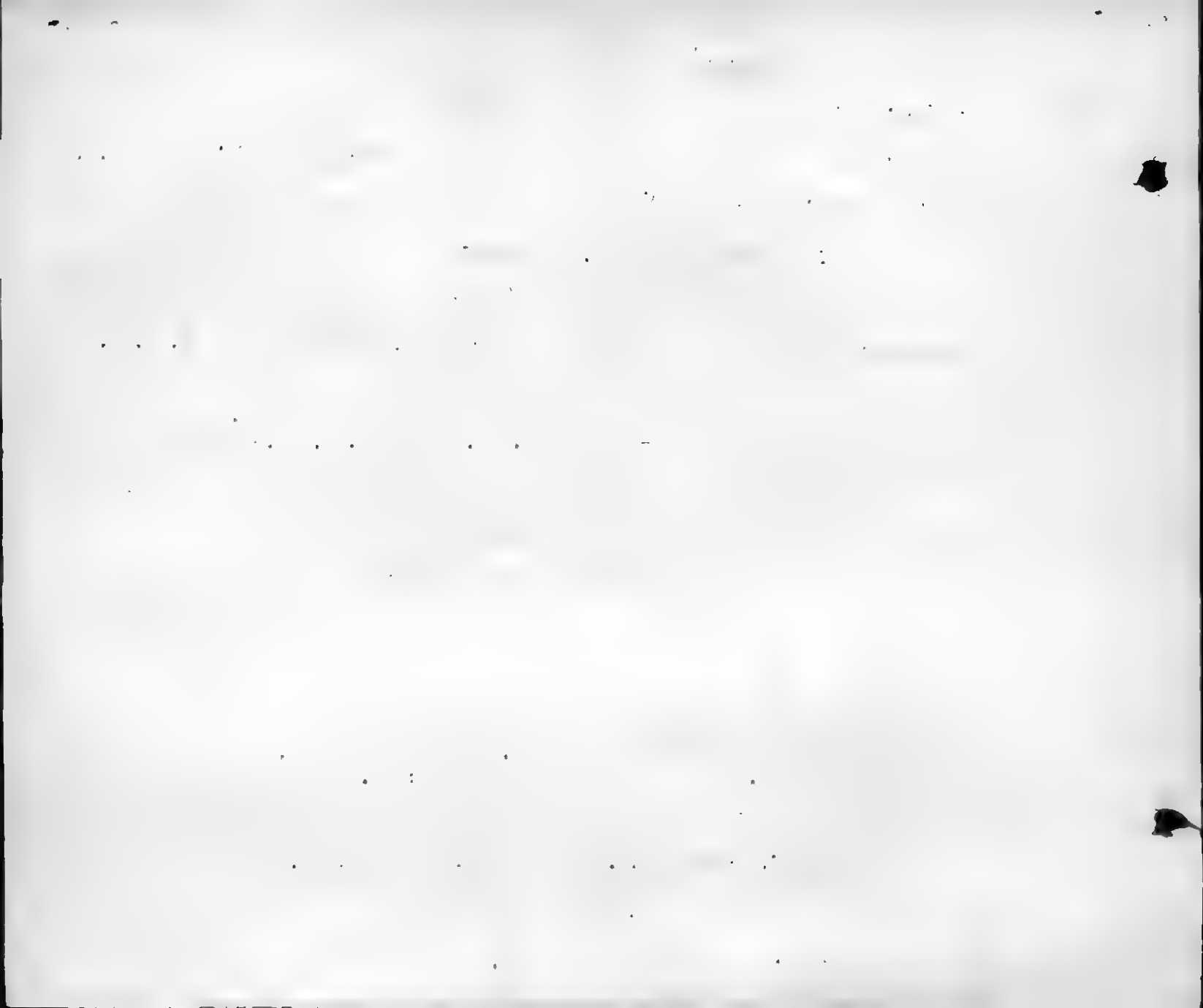


1691

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01677

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>1 Day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore Highlands (Halethorpe P.O.)</b>	
f. STREET ADDRESS <b>2811 Florida Avenue (27)</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>F.</b> Last <b>MARTIN</b>		4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/21/77</b>
9. AGE (In years last birthday) <b>82</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Superintendent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Super Market</b>	
11. BIRTHPLACE (State or foreign country) <b>Brooklyn, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>068-05-8740</b>	
17. INFORMANT <b>Clin. Rec. VAH, Balto. Md. Ft. Howard Division</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> <b>430.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost (b) <b>MYOCARDIAL INFARCTION</b> DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>UNKNOWN</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>20</b> (this hospital) attended the deceased from <b>Feb. 23</b> 19 <b>60</b> , to <b>Feb. 24</b> 19 <b>60</b> , that <b>we</b> lost saw the deceased alive on <b>Feb. 24</b> 19 <b>60</b> , and that death occurred at <b>1:45 PM</b> from the causes and on the date stated above			
22a. SIGNATURE <b>Lawrence D Marcus</b> M.D.		22b. DATE SIGNED <b>2/24/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>LAWRENCE D. MARCUS, M.D.</b>		22d. ADDRESS <b>VAH, BALTIMORE, MD. FORT HOWARD DIVISION</b>	
23a. BURIAL, CREMATON, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-27-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>FLYNN &amp; FLEMING, INC.</b>		25. REC'D BY REGISTRAR DATE <b>FEB 29 '60</b>	
25a. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	





CERTIFICATE OF DEATH

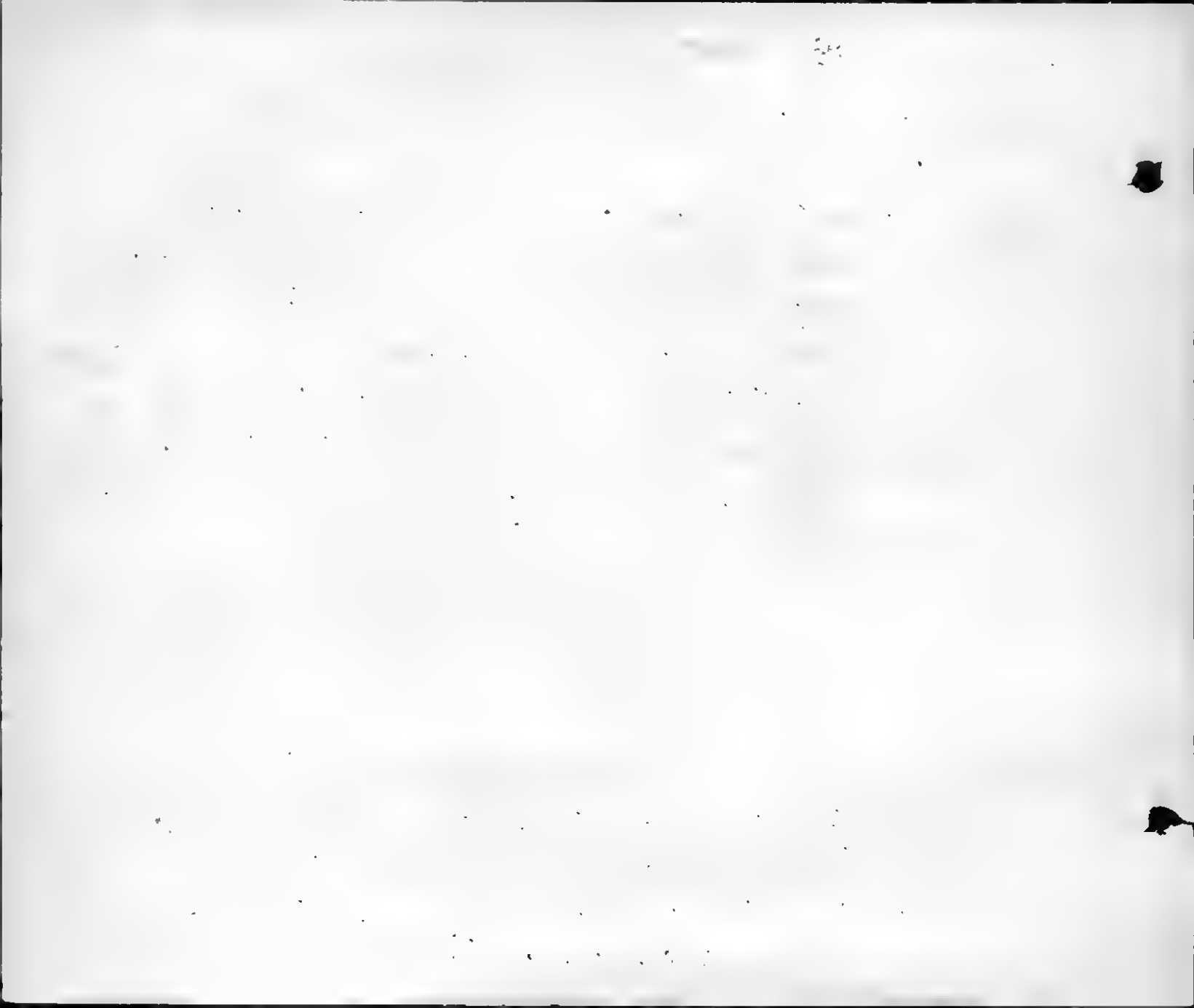
Reg. Dist. No.

01678

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>14</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTO.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>976 MASEFIELD RD.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNA M. MASK</b>				4. DATE OF DEATH Month Day Year <b>FEB. 26, 1960</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 5, 1891</b>	9. AGE (In years last birthday) <b>68</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>D.H.</b>		11. BIRTHPLACE (State or foreign country) <b>IRELAND.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CARNEY</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT Address <b>JOSEPH MASK, 976 MASEFIELD RD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSEPTIC CARDIO</b> <b>4. 1 DUE TO VASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>DUE TO</b> (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 + YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1945</b> to <b>2/26, 1960</b> that I last saw the deceased alive on <b>2/25</b> , 19 <b>60</b> and that death occurred at <b>8 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thos E Pluck</b> M.D.		ADDRESS (Street, city or town, state) <b>3629 Edmondson Ave</b> DATE SIGNED <b>2/29/60</b>					
PHYSICIAN'S NAME (Type) <b>Thos E Pluck</b>		<b>BALTO - 29 - MD</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/29/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>LODON PARK</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WITZKE FUNERAL DIR.</b>		ADDRESS <b>4101 EDMONDSON AVE</b>		24a. REC'D BY REGISTRAR <b>HAR 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Plunk</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1693 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01679

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND				<b>2 USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River (20)</b>		c. LENGTH OF STAY IN 1b <b>14 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 Middle River (20)</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>40 Stabilizer Drive</b>				d. STREET ADDRESS <b>40 Stabilizer Drive</b>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>L. WELDON McALLEN, Jr.</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>February 17th, 1960</b>			
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>May 12, 1911</b>		<b>9. AGE</b> (In years last birthday) <b>48</b> yrs.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Time Study</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Aircraft</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>			
<b>13. FATHER'S NAME</b> <b>L. Weldon McAllen, Sr.</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Laura Fuller</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>218-10-3160</b>		<b>17. INFORMANT</b> <b>Frances D. McAllen</b> Address <b>same as #2</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive C-V Disease</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH  		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. 19		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <b>M. B. Davis</b>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <b>2/19/60</b>			
<b>EXAMINER'S NAME (Type)</b> <b>Melvin B. Davis, M.D.</b>		<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>					
<b>22b. DATE THEREOF</b> <b>2/20/60</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Gardens of Faith</b>		<b>22d. LOCATION (City, town, or county) (State)</b> <b>Baltimore Co., Maryland</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Walter Brooks Bradley, Jr.</b>		<b>ADDRESS</b> <b>Dundalk 22</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b>			
<b>24b. REGISTRAR'S SIGNATURE</b> <b>Wm. S. Thomas</b>							

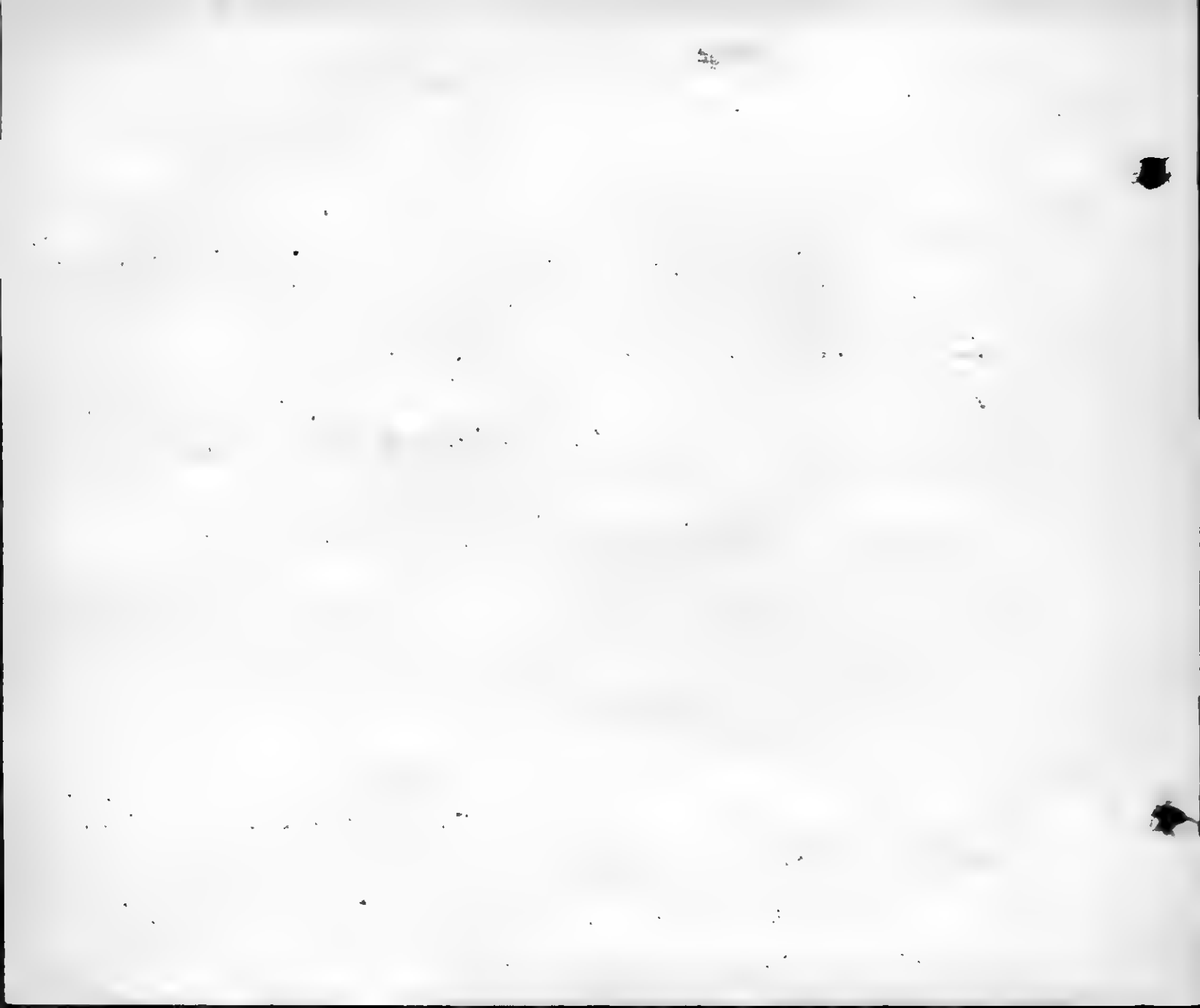
MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.



## Reg. Dist. No.

VS A15 (4)  
15M 9/58



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01681

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>25 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House of the Pines</u>		d. STREET ADDRESS <u>3459 Keswick Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Lela</u> Middle <u>H.</u> Last <u>McFadden</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 10-, 9, 0</u>
9. AGE (In years last birthday) <u>49 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Charwoman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis McFadden</u>		14. MOTHER'S MAIDEN NAME <u>Michaels</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO. <u>220-07-2501</u>	
17. INFORMANT <u>Blanch McFadden</u>		Address <u>3459 Keswick Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rheumatic Heart Disease</u> DUE TO (c) <u>--</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>30 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-8-</u> , 19 <u>60</u> , to <u>2-9-</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-9-</u> , 19 <u>60</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilbur K. Gallagher</u>		ADDRESS (Street, city or town, state) <u>6209 Freedom Ave. Baltimore-28, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Wilbur K. Gallagher</u>		DATE SIGNED <u>2-11-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 12-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Pk. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Calvin J. Perry</u>		ADDRESS <u>5646 Carville Ave.</u>	24a. REC'D BY REGISTRAR DATE <u>FEB 16 '60</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# Item 9 Film 257 3-2-60 et 1696 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

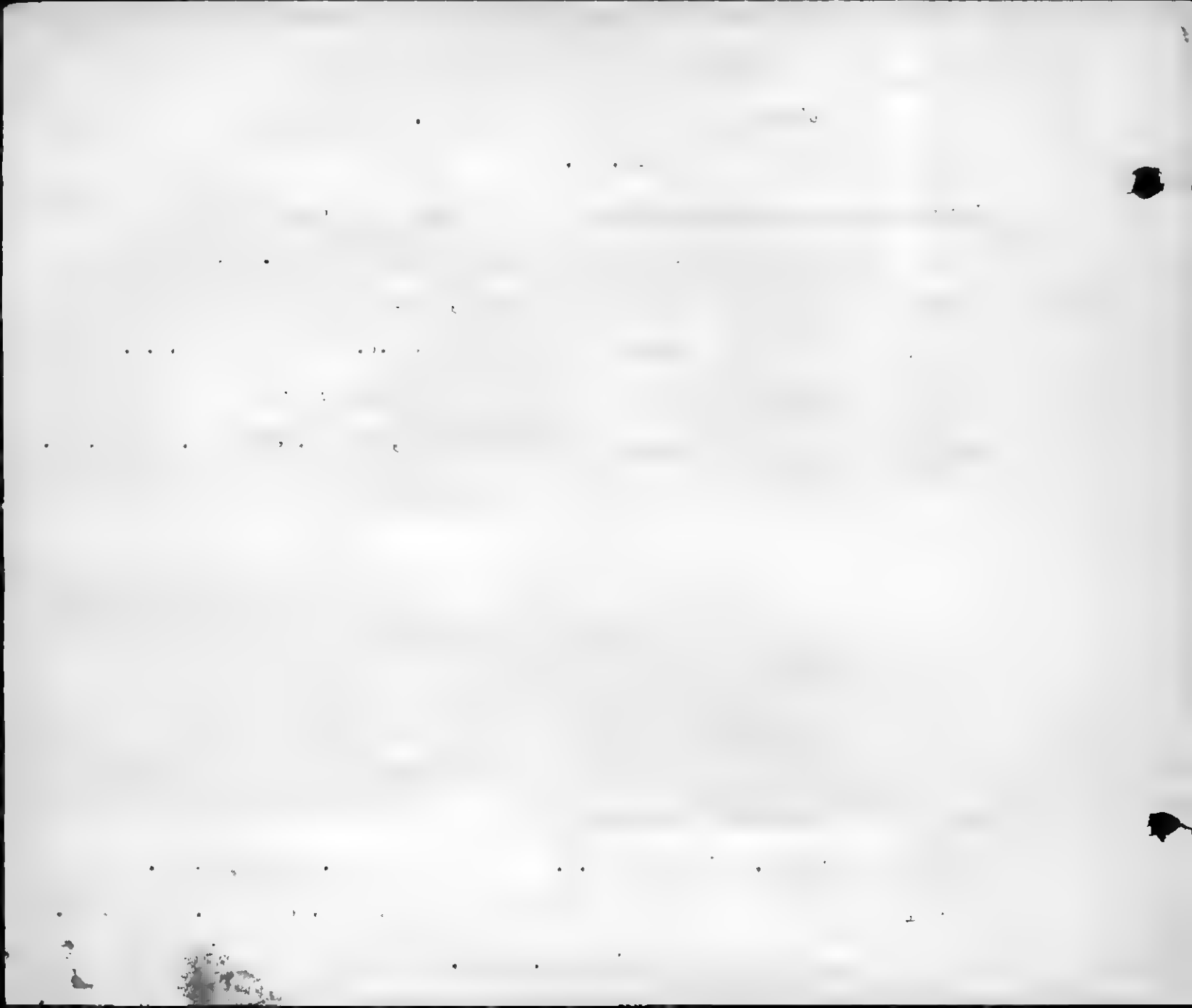
Reg. Dist. No.

01682

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Convent of the Mission Helpers of the Sacred Heart</b>		d. STREET ADDRESS <b>1001 West Joppa Road</b>	
3. NAME OF DECEASED (Type or print) <b>Sister Mary Evangelista (McGovern)</b>		4. DATE OF DEATH <b>Feb. 26, 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1881</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nun</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Convent</b>	11. BIRTHPLACE (State or foreign country) <b>Trenton, N.J.</b>
13. FATHER'S NAME <b>Francis McGovern</b>		14. MOTHER'S MAIDEN NAME <b>Honora McCarthy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Convent Records, 1001 W. Joppa Rd. Towson, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Rheumatoid Arthritis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/30</b> , 19 <b>59</b> , to <b>1/30</b> , 19 <b>60</b> that I last saw the deceased alive on <b>1/30</b> , 19 <b>60</b> , and that death occurred at <b>12:00</b> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles W. Wainwright</b>		DATE SIGNED <b>FEB 26 1960</b>	
PHYSICIAN'S NAME (Type) <b>Charles W. Wainwright, M.D.</b>		9 East Chase St. Baltimore, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/29/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Convent Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>1001 W. Joppa Rd. Towson, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Vernon Lemmon</b>		ADDRESS <b>4611 Park Heights A. Balto.</b>	
24a. REC'D BY REGISTRAR <b>FEB 29 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 4, 5, 6, 7, and 8 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

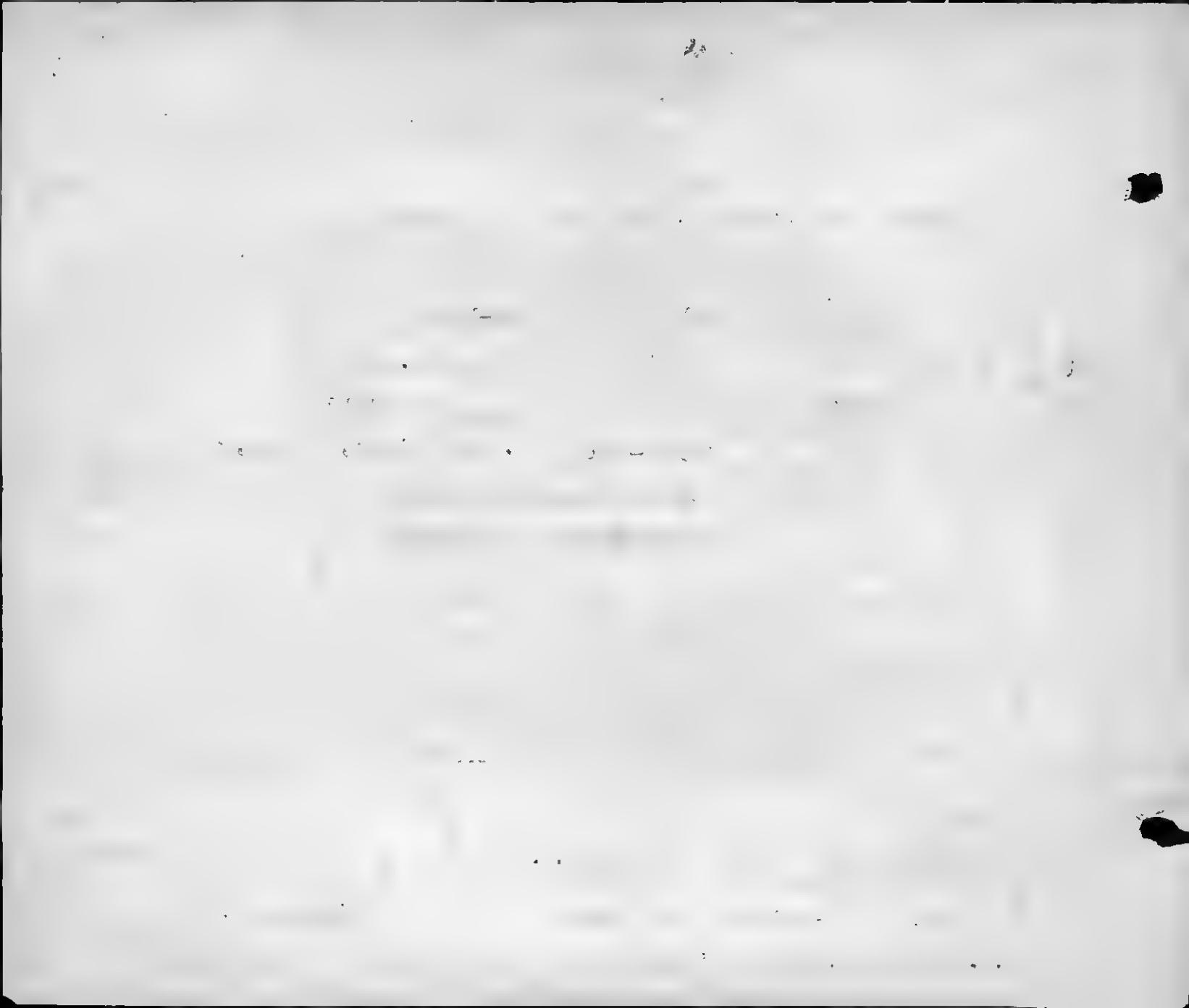
VS. A15ME  
5M 7/59

Item 18 Film 258  
3-10-60 amp

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0683

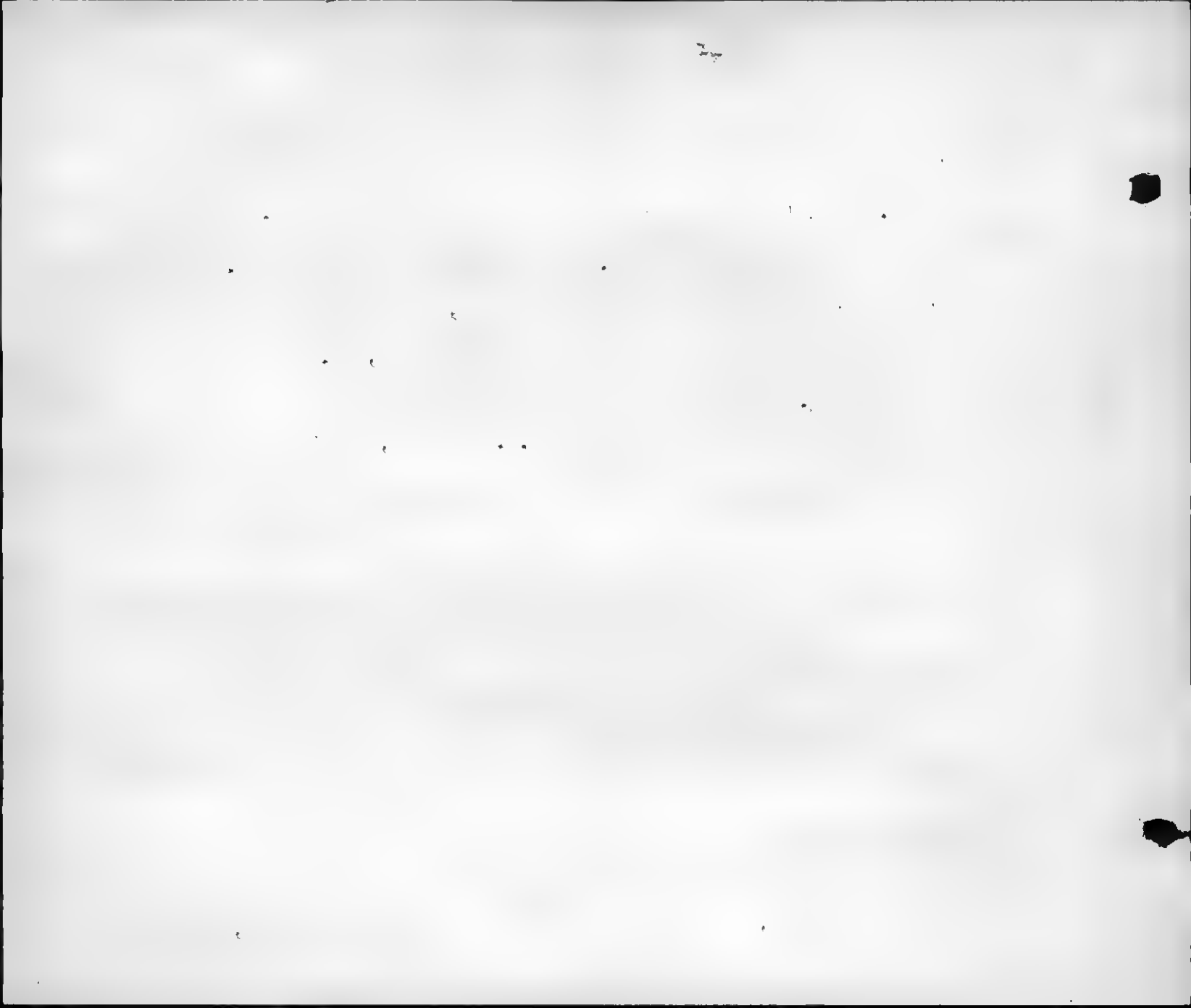
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Abandoned railway track to Ellicott City</b>		e. STREET ADDRESS <b>Ellicott City</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) <b>GEORGE THOMAS McKINZE</b>		4. DATE OF DEATH Month <b>February</b> Day <b>16</b> Year <b>1960</b>		5. SEX <b>Male</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-2-1908</b>		9. AGE (In years last birthday) <b>51</b> yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>		11. BIRTHPLACE (State or foreign country) <b>Howard Co. Md</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Howard Co. Md</b>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-09-6196</b>		17. INFORMANT <b>Mrs. Mary Knisley, Guilford, Md</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Alcohol intoxication</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Exposure to freezing temperature</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <b>Peter W. Reel</b>		M.D. <b>Peter Reckert, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Peter Reckert, M.D.</b>		Address (Street, city, town, or county) <b>Ellicott City, Md</b>		DATE SIGNED <b>2/17/60</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-19-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>	
23. FUNERAL DIRECTOR <b>F.C. Higinbotham, Ellicott City, Md</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>FEB 23 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Ciriling S. Krause</b>		25. LOCATION (City, town, or country) (State)		26. REGISTRAR'S SIGNATURE	



## 01684

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>						2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>						c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Joseph's Nursing Home</b>						d. STREET ADDRESS <b>333 Tunbridge Rd.</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last <b>Isabella B. Mc Nulty</b>						Month Day Year <b>Feb. 29 1960</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 16, 1877</b>		9. AGE (In years last birthday) <b>82 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Jesse K. Hall</b>						14. MOTHER'S MAIDEN NAME <b>Ann Keelan</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO		17. INFORMANT Address <b>Thos.F. Mc Nulty, Jr 333 Tunbridge Road</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Hemorrhage (Nucleus)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension Arteriosclerosis</b>											
INTERVAL BETWEEN ONSET AND DEATH <b>4 m. 15 y.</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1/20, 1960</b> , to <b>2/29, 1960</b> , that I last saw the deceased alive on <b>2/29, 1960</b> , and that death occurred at <b>4:12 P.M.</b> , from the causes and on the date stated above.											
ADDRESS (Street, city or town, state) DATE SIGNED <b>1102 E. Lexington Rd Baltimore, Md 5/2/60</b>											
ACTUAL SIGNATURE <b>Victor F. Ziegler</b> M.D.											
PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>March 4, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>H.W. Meas - Son 605 N. Calvert St.</b>											
24a. REC'D BY REGISTRAR DATE <b>MAR 3 '60</b>				24b. REGISTRAR'S SIGNATURE <b>Carlton L. Frank</b>							

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ISM 10/57



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1699

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

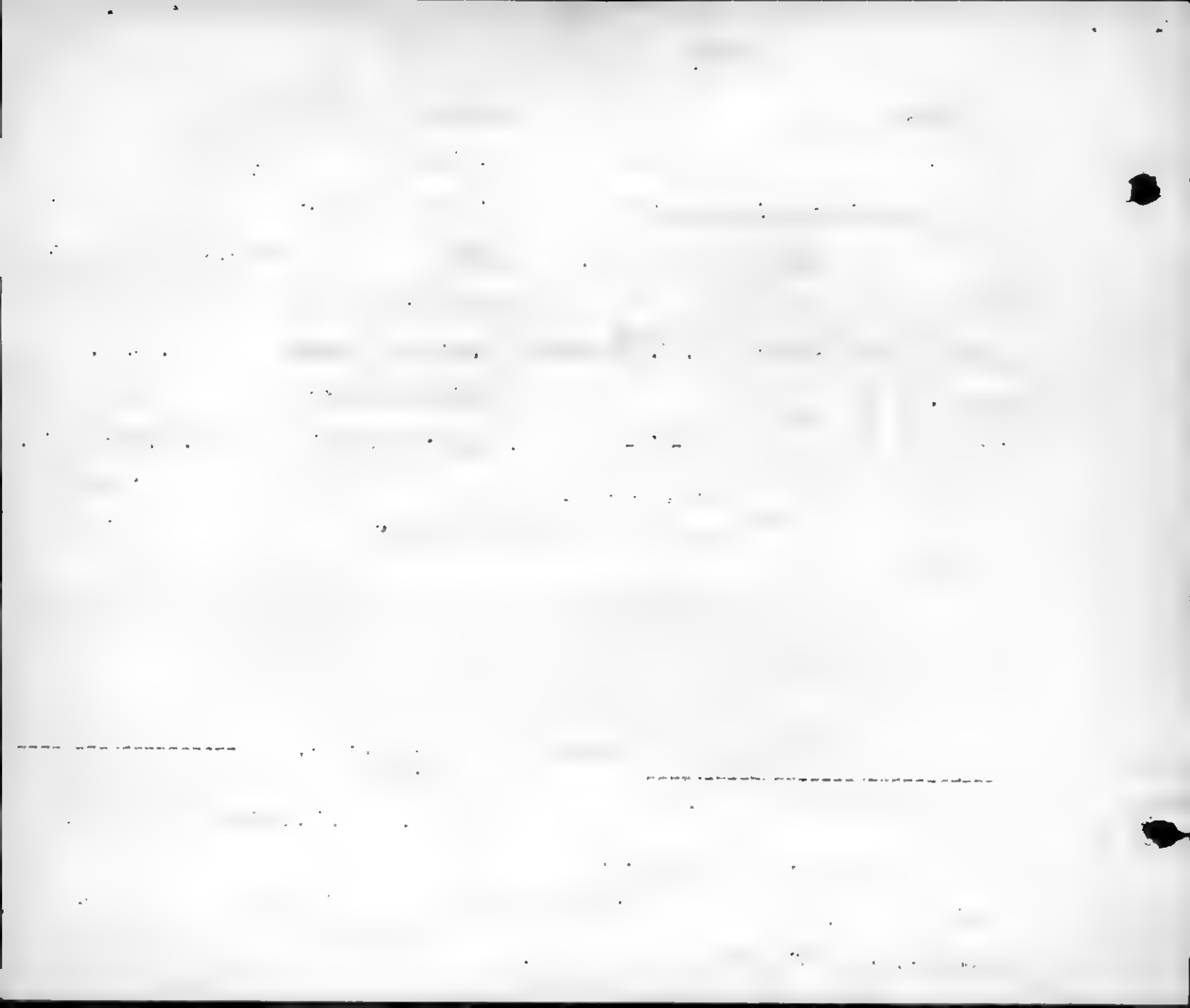
Reg. Dist. No.

01685

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN lb <b>97 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>2764 Tivoly Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>LLOYD</b> Middle <b>W.</b> Last <b>MELVIN</b>				4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 14, 1895</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Deputy Collector-Retired U. S. Government</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Customs</b>			
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>John W. Melvin</b>				14. MOTHER'S MAIDEN NAME <b>Lillie Mae Decker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>				16. SOCIAL SECURITY NO <b>218-367-692</b>			
17. INFORMANT <b>Clin. Records, VAM, Baltimore 18, Md. Ft. Howard Div.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>491x</b> <b>EXCER</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA OF LUNG WITH METASTASIS</b> (c) <b>UNKNOWN</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>October 28, 1959</b> to <b>February 2, 1960</b> that I last saw the deceased <b>alive on</b> <b>12-7</b> and that death occurred at <b>10:00 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Walter C. Goldstein</b> M.D. <b>VAM, BALTO. 18, MD. FT. HOWARD DIVISION 2/2/60</b>							
ACTUAL SIGNATURE <b>WALTER C. GOLDSTEIN, M.D.</b>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/5/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck 5005 Harford Rd., Balto. Md.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 3 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





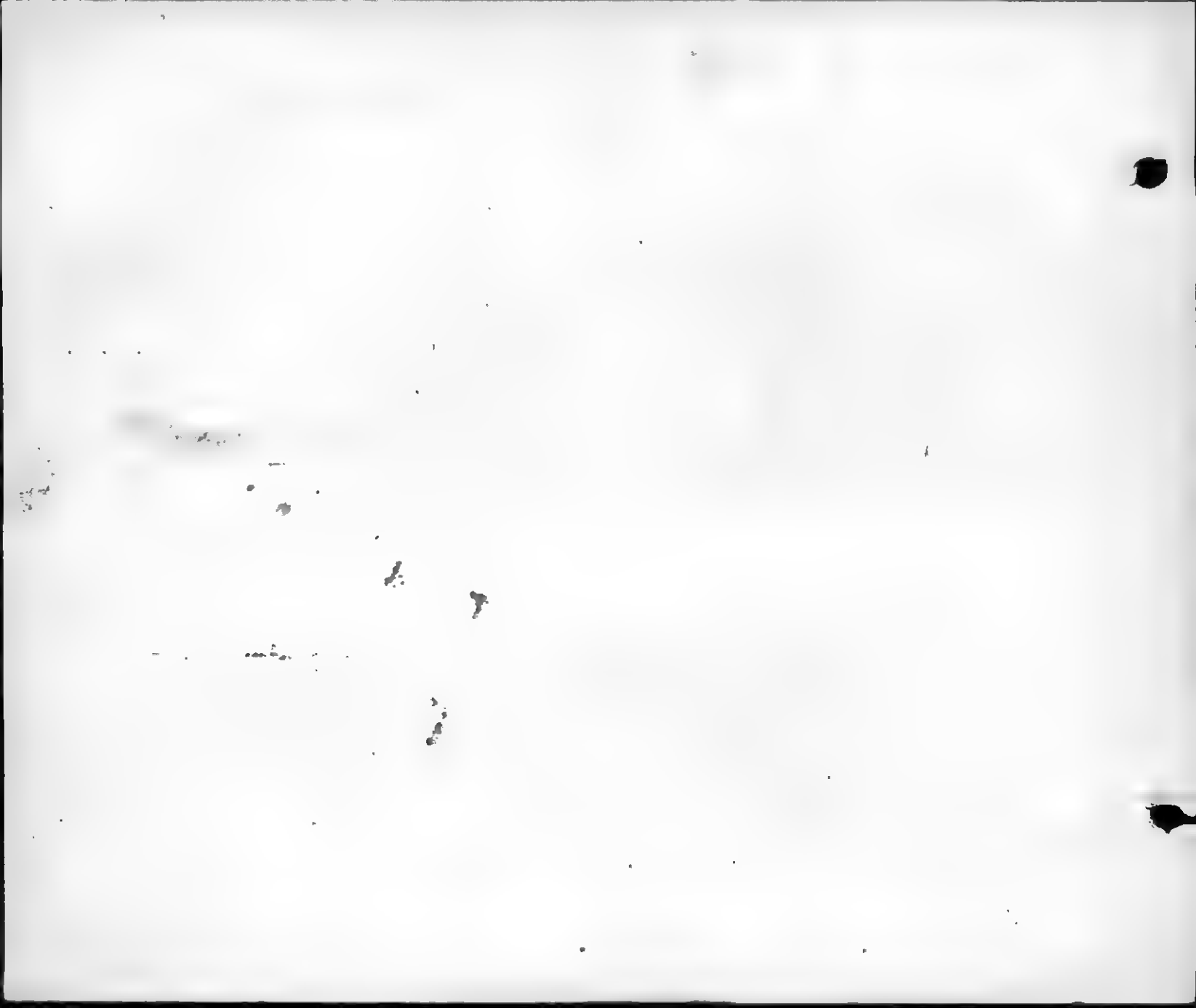
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1700 CERTIFICATE OF DEATH

Reg. Dist. No.

01686

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2yr11mth15days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
f. STREET ADDRESS <b>228-222 Athol Avenue</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bertha</b> Middle <b>A.</b> Last <b>Merritt</b>		4. DATE OF DEATH Month <b>February</b> Day <b>23</b> Year <b>19 60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 13, 1880</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>0 H.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Schue</b>		14. MOTHER'S MAIDEN NAME <b>Melvina</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
INFORMANT Address Records: <b>SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> (c) <b>Generalized arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m., p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec. 15, 1958</b> to <b>Feb. 23, 1960</b> that I last saw the deceased alive on <b>Feb. 23, 1960</b> and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachler</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>2-23-60</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachler, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/27/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Matthews</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F.D. 4101 Edmondson Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 26 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			



1

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1701 CERTIFICATE OF DEATH

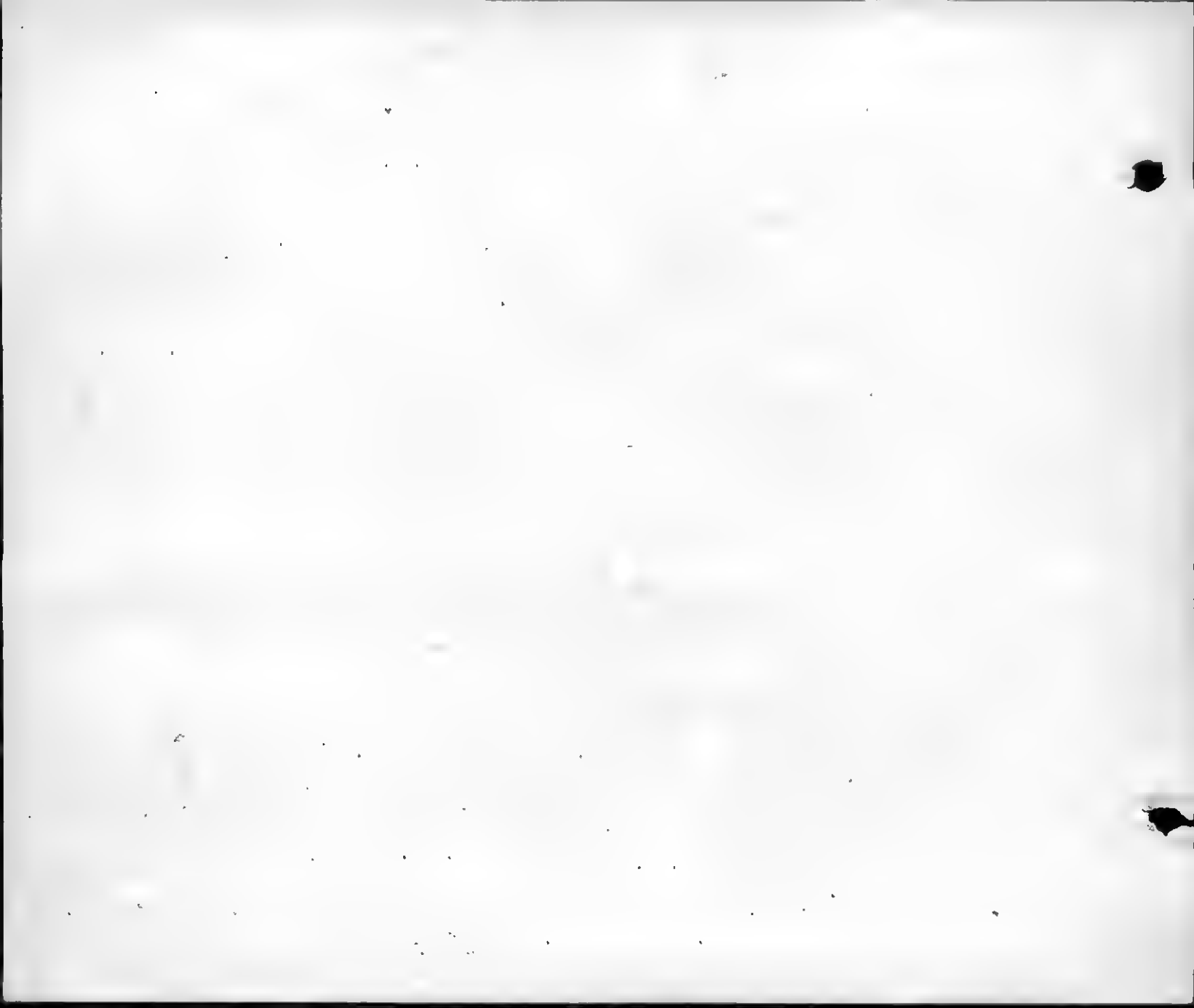
01687

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN lb <u>15yrlmthl7dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
f. STREET ADDRESS <u>48 Market Place</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle Last <u>Michaels</u>		4. DATE OF DEATH Month <u>February</u> Day <u>19</u> Year <u>19 60</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16, 1892</u>
9. AGE (In years last birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Michaels</u>		14. MOTHER'S MAIDEN NAME <u>Sophie Walters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>219-01-1610</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac failure</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of the nose</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I attended the deceased from <u>Feb. 3</u> , 19 <u>51</u> , to <u>Feb. 19</u> , 19 <u>60</u> , that I lost sows the deceased alive on <u>Feb. 19</u> , 19 <u>60</u> , and that death occurred at <u>4:00a</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachler</u>		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>2-19-60</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachler, M. D.</u>		Catonsville 28, Maryland	
22a. RITIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/24/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>4300 eed Frederic</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Faley &amp; Sons</u>		24a. REC'D BY REGISTRAR <u>1318</u> FEB 25 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1702

## CERTIFICATE OF DEATH

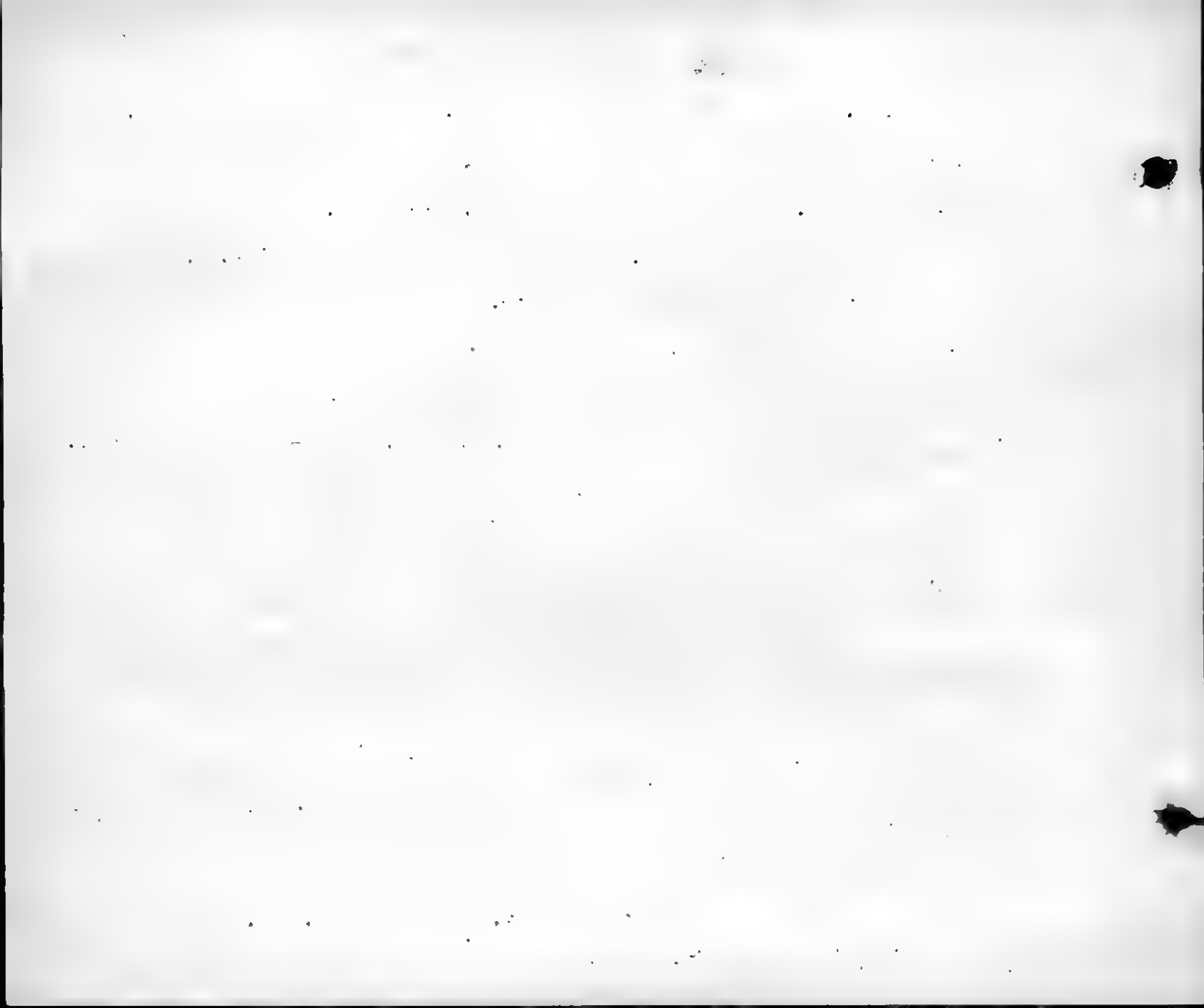
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b> X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2111 Northland Rd.</b>				d. STREET ADDRESS <b>2111 Northland Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>LAURA</b> Middle <b>C.</b> Last <b>MILLER</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>6</b> Year <b>19 60</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 6, 1876</b>	9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Unknown/ Thomas Howard</b>				14. MOTHER'S MAIDEN NAME <b>Unknown/ Margaret Ward</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>		16. SOCIAL SECURITY NO. <b>none</b>		INFORMANT Address <b>Mrs. Marie C. Marks - 2111 Northland Rd. #7</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>170 X</b> <b>170 X</b> DUE TO <b>Larcinoma of Breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1950</b> to <b>Feb. 6, 1960</b> , that I last saw the deceased alive on <b>Feb. 5, 1960</b> and that death occurred at <b>4:45 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1039 47th Ave. N.W. Wash. D.C.</b> DATE SIGNED <b>2/6/60</b>							
ACTUAL SIGNATURE <b>Lester A. Wall Jr</b> M.D.				PHYSICIAN'S NAME (Type) <b>LESTER A. WALL JR</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/9/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Ticken &amp; Sons - Wash 17th</b>				24a. REC'D BY REGISTRAR <b>FEB 9 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01689

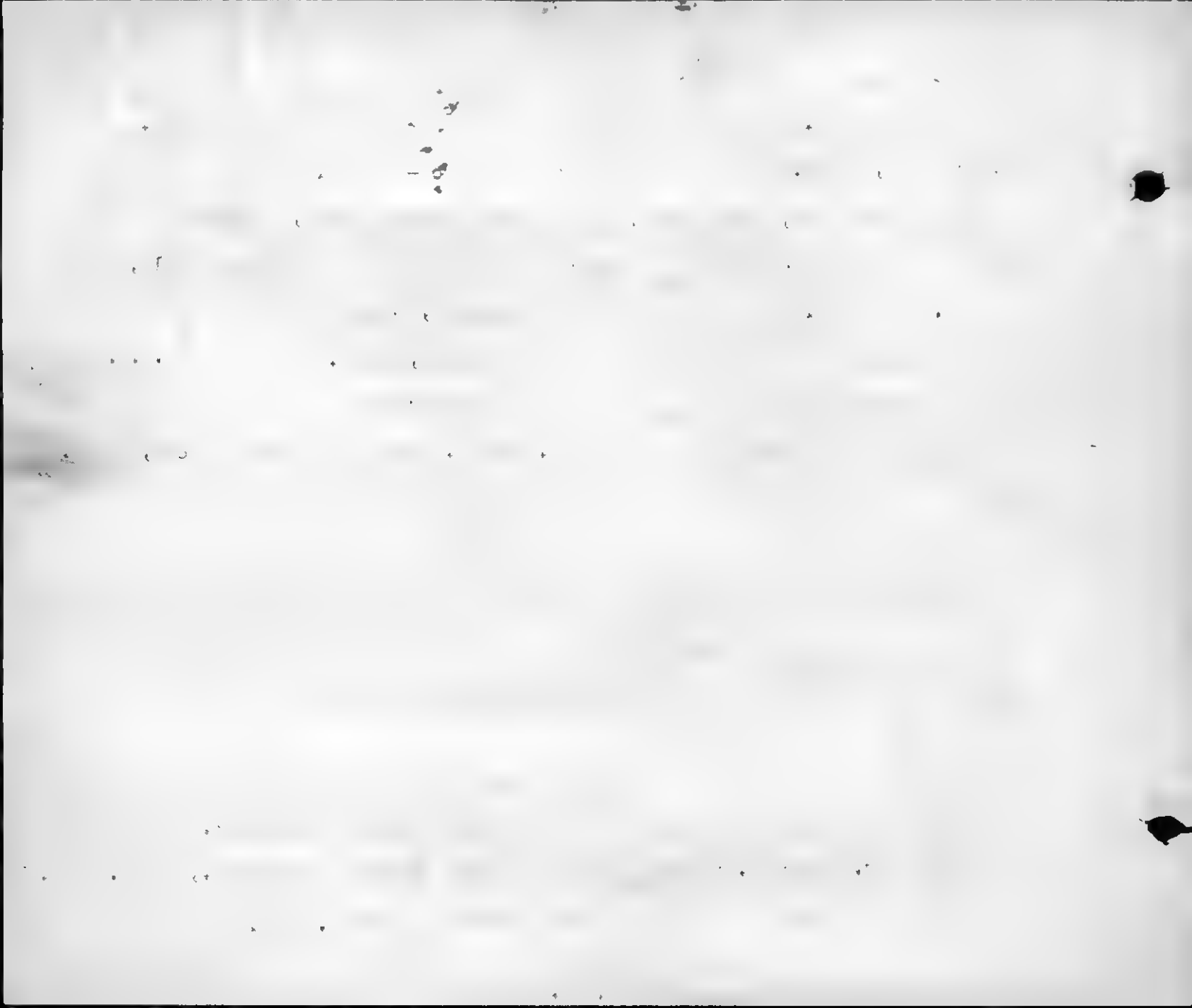
1703 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b>		b. STATE <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Villa Nova, Balto. 7</b>		c. LENGTH OF STAY IN 1b <b>About 4 Yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Formally of- Balto. City</b>		<b>3v-1.4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Robbs Nursing Home, Essex Road,</b>		d. STREET ADDRESS <b>3129 Normount Avenue, Zone 16</b>		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Agnes Sander Moll</b>		4. DATE OF DEATH Month Day Year <b>February 17, 1960</b>					
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARITAL STATUS <b>WIDOWED</b>	8. DATE OF BIRTH <b>October 1, 1872</b>	9. AGE (In years last birthday) <b>87</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Marietta, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Sander</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Kock</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>*****</b>		17. INFORMANT <b>Mr. John S. Moll</b>		Address <b>3716 Campfield Road, Balto. 7</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work Not while of work <input type="checkbox"/> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>948</b> , 19 <b>60</b> , to <b>2117</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>2/17</b> , 19 <b>60</b> , and that death occurred at <b>7 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4300 Liberty Heights Ave., Balto.</b> DATE SIGNED <b>2/19/60</b>							
ACTUAL SIGNATURE <b>Edward S. Kallins</b>		M.D. <b>4300 Liberty Heights Ave., Balto.</b>					
PHYSICIAN'S NAME (Type) <b>Dr. Edward S. Kallins</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/19/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers</b>				ADDRESS <b>8728 Liberty Road</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 24 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL CERTIFICATION

2014315XV5



CERTIFICATE OF DEATH

Reg. Dist. No.

01691

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>MARYLAND</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RUXTON</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RUXTON</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1201 BERWICK AVE.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDMUND TILESTON MUDGE II</b>				4. DATE OF DEATH Month Day Year <b>2 27 1960</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-21-95</b>		9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>EXECUTIVE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WHOLESALE PAPER</b>		11. BIRTHPLACE (State or foreign country) <b>MO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>FRANK MUDGE</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET LOUISE SIMON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW.I</b>		16. SOCIAL SECURITY NO. <b>214-03-5335</b>		17. INFORMANT Address <b>E.T. MUDGE III 1208 JOHN ST. BALTO, MO</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>445 X</b> DUE TO <b>Vermia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>malignant hypertension</b> (c) <b>arterio- &amp; arteriole necrosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>9 mos</b> <b>sev. ylns</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cont. hypertension</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1953</b> , to <b>present</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Feb 27</b> , 19 <b>60</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ernest C Brown Jr</b>				ADDRESS (Street, city or town, state) <b>1101 N. Calvert St, Balt 2</b> DATE SIGNED <b>2/28/60</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-29-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>DRUID RIDGE</b>		22d. LOCATION (City, town, or county) (State) <b>PIKESVILLE MO.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. JENKINS &amp; SONS CO.</b> ADDRESS <b>4905 YORK RD BALTO. MO</b>				24a. REC'D BY REGISTRAR <b>MAR 2 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

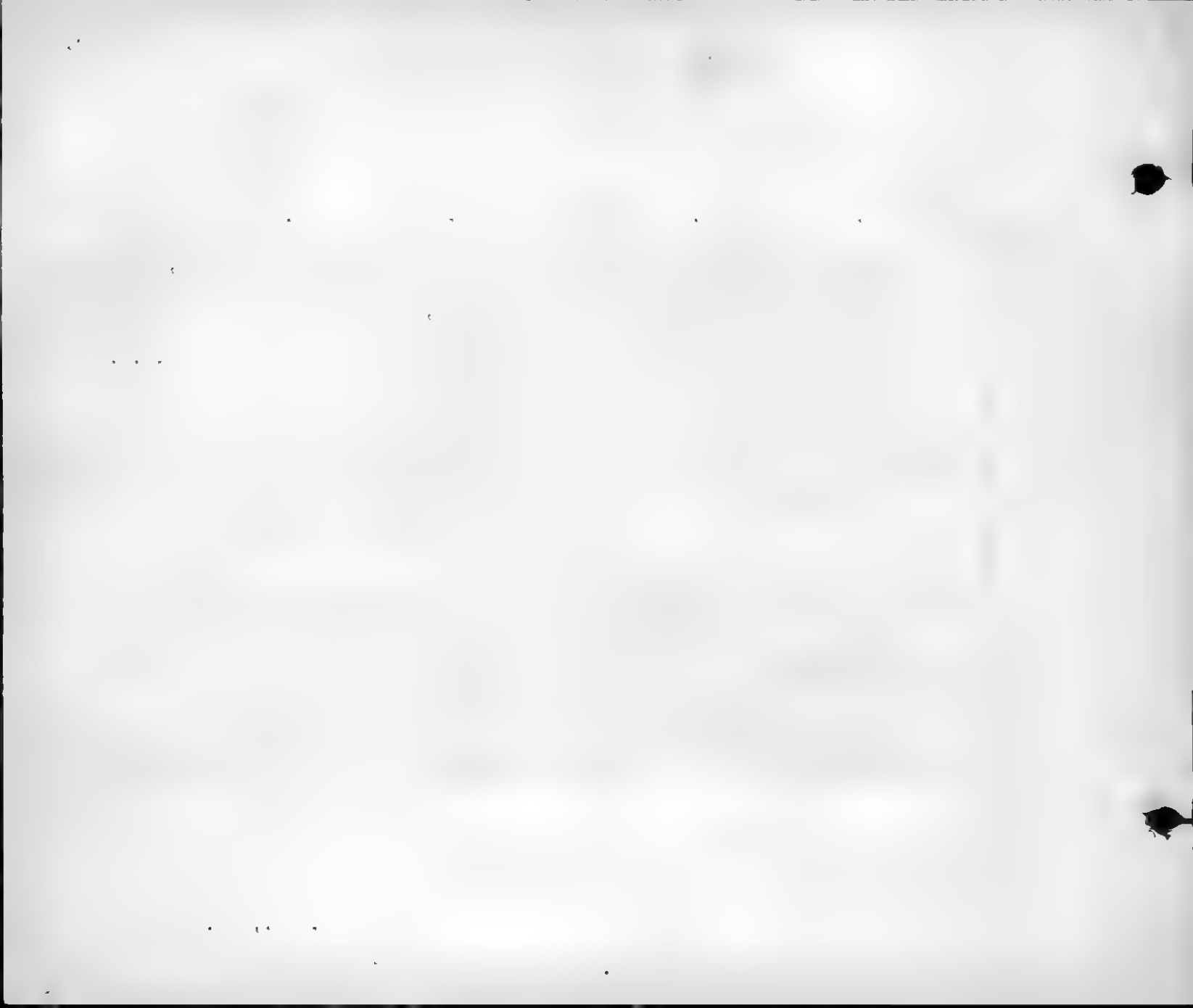
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1706 CERTIFICATE OF DEATH

01692

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		c. LENGTH OF STAY IN 1b (21)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 212 S. Margaret Ave.				d. STREET ADDRESS 212 S. Margaret Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BRIDGET (MUDINISKI) MUDINKA				4. DATE OF DEATH February 28, 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 1, 1874	
9. AGE (In years last birthday) 86 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Helen Ziemba Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Cerebral thrombosis</i> DUE TO <i>Generalized arteriosclerosis</i> underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis heart disease with failure</i>						INTERVAL BETWEEN ONSET AND DEATH <i>17 weeks</i> <i>3 yrs.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 1959</i> to <i>1/11 1960</i> , that I last saw the deceased alive on <i>1/26 1960</i> , and that death occurred at <i>6:15 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>434 Eastern Ave</i> DATE SIGNED <i>Emery md</i>							
ACTUAL SIGNATURE <i>J. Platt</i>		M.D. <i>434 Eastern Ave</i>					
PHYSICIAN'S NAME (Type) J. PLATT, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/7/60		22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		22d. LOCATION (City, town, or county) (State) Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James Bruzdinski</i> James Bruzdinski 1407 Eastern Ave.				24a. REC'D BY REGISTRAR DATE <i>MAR 1 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Curtis S. Kline</i>	









1707 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

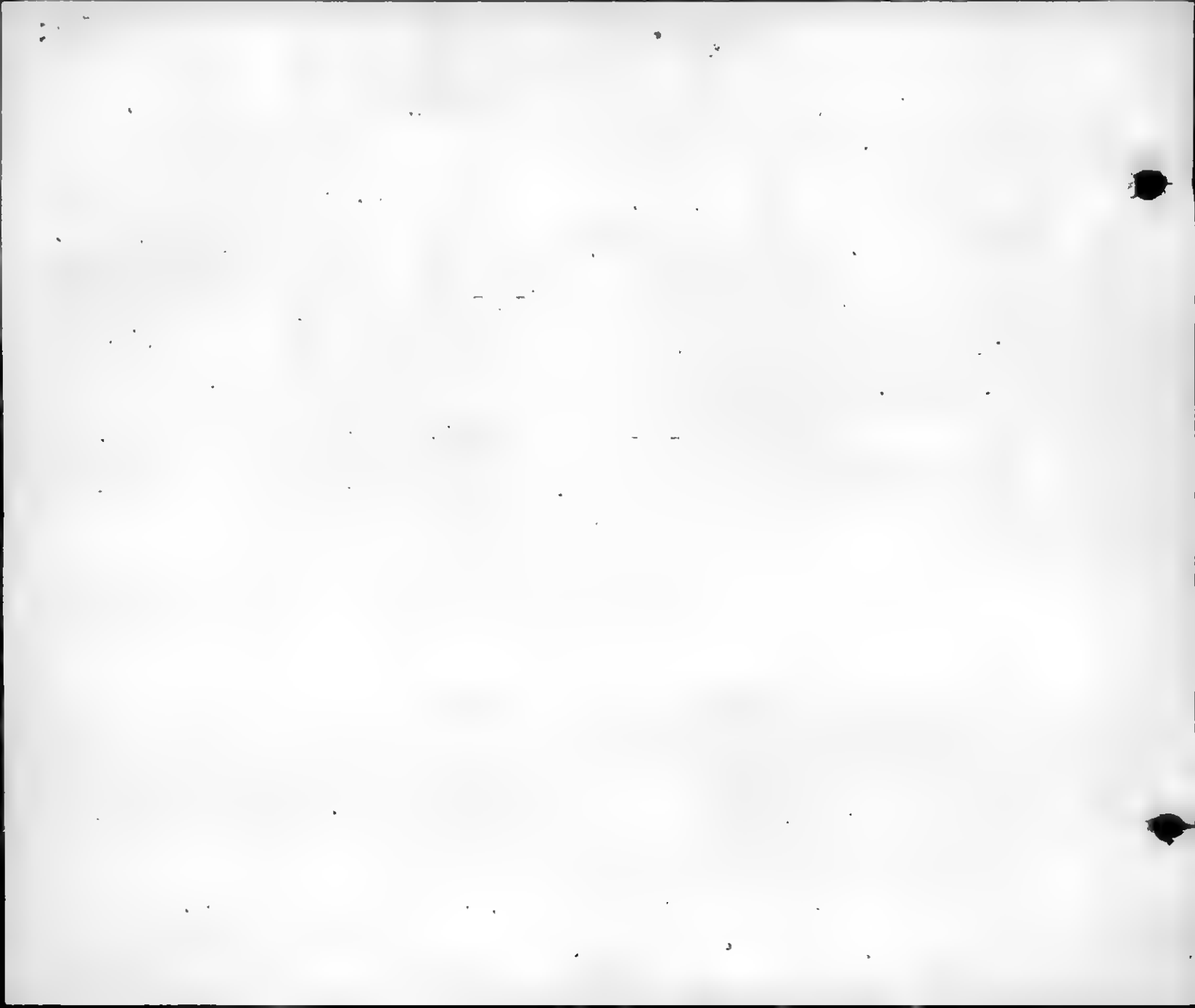
CERTIFICATE OF DEATH

01694

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3031 Edgewood Ave.</u>		d. STREET ADDRESS <u>13031 Edgewood Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Mr. George</u> Middle <u>W.</u> Last <u>Nelson</u>		4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15-1884</u>
9. AGE (In years last birthday) yrs. <u>75</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) <u>Maintenance man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George Nelson</u>	
14. MOTHER'S MAIDEN NAME <u>Longemann</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>217-03-1913</u>		INFORMANT Address <u>Catherine Bender 8502 James Ave. 14</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>Arteriosclerosis (a-compensated) heart</u> DUE TO <u>hypertension</u> (c) <u>hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Feb</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 14, 1960</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert J. Ruck</u>		M.D. <u>3004 E. 1st St. B. 157, Bk. 1, 3/10/60</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>2-18-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

01695

1708

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> <u>3V-1-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOUSE IN THE PINES NURSING &amp; CONVALESCENT HOME</u>				d. STREET ADDRESS <u>120 N. HILTON ST</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>J.</u> Last <u>Newell, Sr.</u>				4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-15-1880</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u>		IF UNDER 24 HRS Hours <u>10</u> Min. <u>30</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED STATIONARY ENGINEER NATIONAL BREWERY</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>IRELAND</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>MICHAEL NEWELL</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE A. BURKE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-05-4070</u>		17. INFORMANT <u>MRS. CATHERINE EBBERT</u> Address <u>15 LINCOLN DR, ELICOTT CITY, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Hypertension Cardio-Vascular, Dec 1942</u> DUE TO Lying cause last. (c) <u>10 yrs.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>12-30-1959</u> to <u>2-9-1960</u> , that I last saw the deceased alive on <u>2-9-1960</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>				ADDRESS (Street, city or town, state) <u>6209 Frederick Ave</u> DATE SIGNED <u>2-9-60</u>			
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>				Baltimore-28, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-13-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Walter Conklin</u>				ADDRESS <u>5444 BELAIR RD, BALTO.</u>		24a. REC'D BY REGISTRAR DATE <u>2-12-60</u>	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



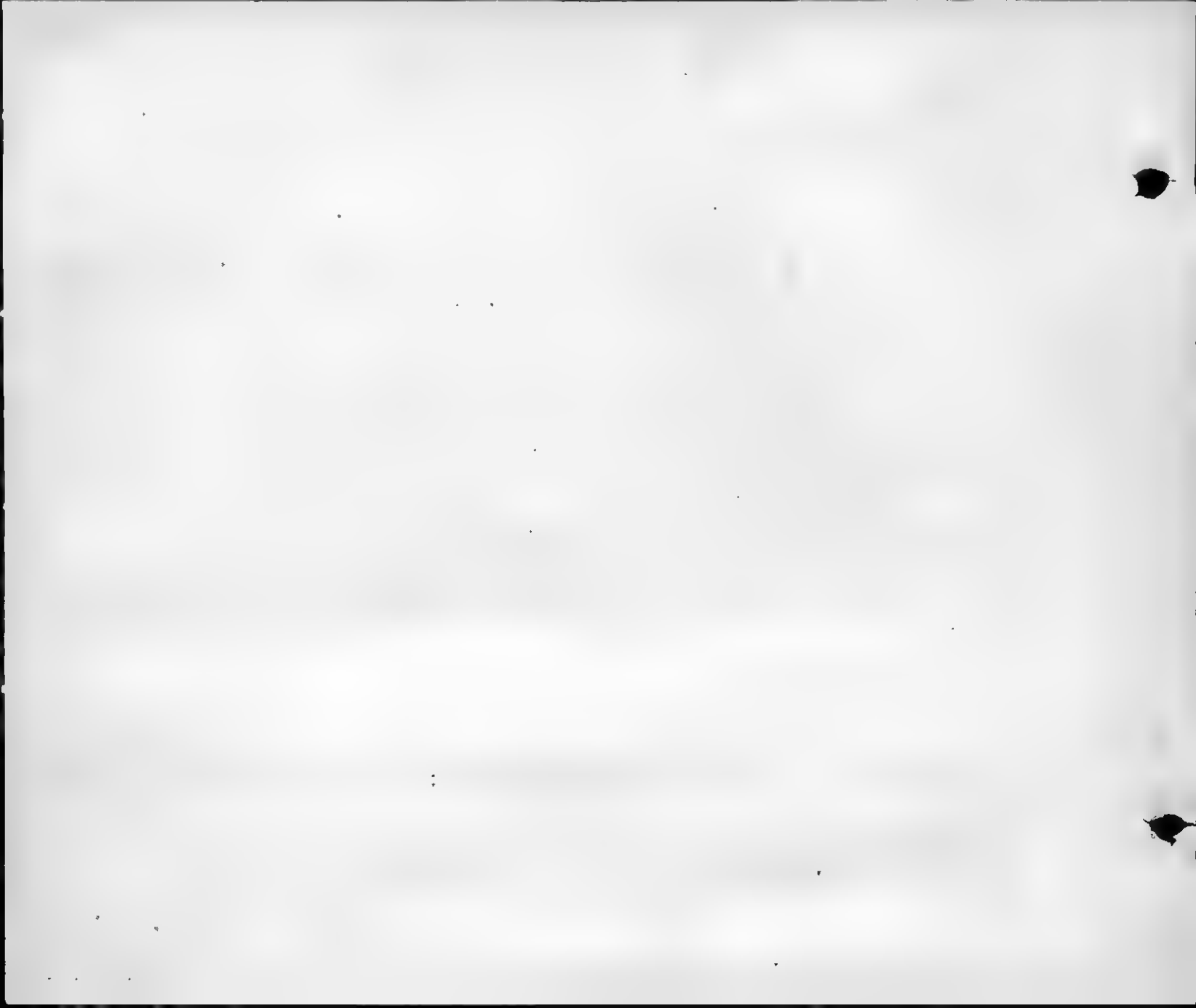
## 1709 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>51 Baltimore (27)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgeway Manor Nursing Home</u>				d. STREET ADDRESS <u>5511 Council St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Nitkiewicz</u> Last				4. DATE OF DEATH Month <u>Feb.</u> Day <u>18th</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 29th 1885</u>	
9. AGE (In years last birthday) <u>74</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>Poland.</u> ✓	
13. FATHER'S NAME <u>Grzywna</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>William Rojsza 5511 Council St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>							
422.1 DUE TO <u>Cardio Vascular Disease</u>							
(b) DUE TO							
(c) DUE TO							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma Left Breast 1954. Rt Breast 1958</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>7/15</u> , 19 <u>52</u> , to <u>2/18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/18</u> , 19 <u>60</u> , and that death occurred at <u>6:40 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eliot W. Johnson</u>				ADDRESS (Street, city or town, state) <u>3432 Frederick Ave Baltimore 29 Md</u>			
PHYSICIAN'S NAME (Type) <u>Eliot W. Johnson</u>				DATE SIGNED <u>2/14/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-22-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Water Dolorosa</u>		22d. LOCATION (City, town, or county) (State) <u>South Hadley Cont. Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George A. Weber Jr. 5614 Carville Ave</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>John A. Johnson</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



18  
1  
Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1710 CERTIFICATE OF DEATH

01697

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Y</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MIDDLE RIVER</b>				c. LENGTH OF STAY IN 1b <b>6 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>190 IVY HALL NURSING HOME</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CHARLES H. NORANBROCK, SR.</b>				4. DATE OF DEATH <b>FEB. 26 1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 24, 1870</b>	
9. AGE (In years last birthday) <b>89</b>		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER - WOMBLE Lumber</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MD.</b>			
11. BIRTHPLACE (State or foreign country) <b>MD.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>NOT KNOWN</b>				14. MOTHER'S MAIDEN NAME <b>NOT KNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>216-18-4829</b>			
17. INFORMANT <b>ED. NORANBROCK, SR.</b>				Address <b>405 S. BONJAL ST.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>442x ARTERIOSCLEROTIC CARDIOVASCULAR RENAL DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c) <b>DUE TO</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>0</b>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>6/8 1954</b> to <b>2/26 1960</b> that I last saw the deceased alive on <b>2/26 1960</b> and that death occurred at <b>1 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>121 S. HIGHLAND AVE. BALTO. MD.</b> DATE SIGNED <b>MAR 20 24 1960</b>							
ACTUAL SIGNATURE <b>Benjamin H. Hirstein</b> M.D.				PHYSICIAN'S NAME (Type) <b>B. H. HIRSTEIN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>MAR. 1, 1960</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>MT. CARMEL</b>				22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Geo. W. Hoffmann</b>				ADDRESS <b>3218 HUDSON ST.</b>			
24a. REC'D BY REGISTRAR <b>DATE FEB 29 '60</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			





## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenarm.</u> c. LENGTH OF STAY IN 1b <u>3 1/2 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenarm Rd.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenarm</u> d. STREET ADDRESS <u>Glenarm Rd. Balto Co</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret- Ethel North.</u>		4. DATE OF DEATH <u>Feb 23 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 11 1877</u>
9. AGE (In years last birthday) <u>82 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elmer A. Robertson</u>		14. MOTHER'S MAIDEN NAME <u>Marjory Ellen Parker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Husband</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial ischemia</u> <u>4</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocarditis and degeneration</u> (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>5+ yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 1956</u> to <u>Feb 1960</u> , that I last saw the deceased alive on <u>Feb 14 1960</u> , and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank T. Kasuk Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>9005 HARRFORD RD BALTO MD</u>	
PHYSICIAN'S NAME (Type) <u>FRANK T KASUK JR.</u>		DATE SIGNED <u>2/23/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-27-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Park</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard Kuch</u> ADDRESS <u>5305 Hurford</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 26 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL: The attending physician: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 1712 CERTIFICATE OF DEATH

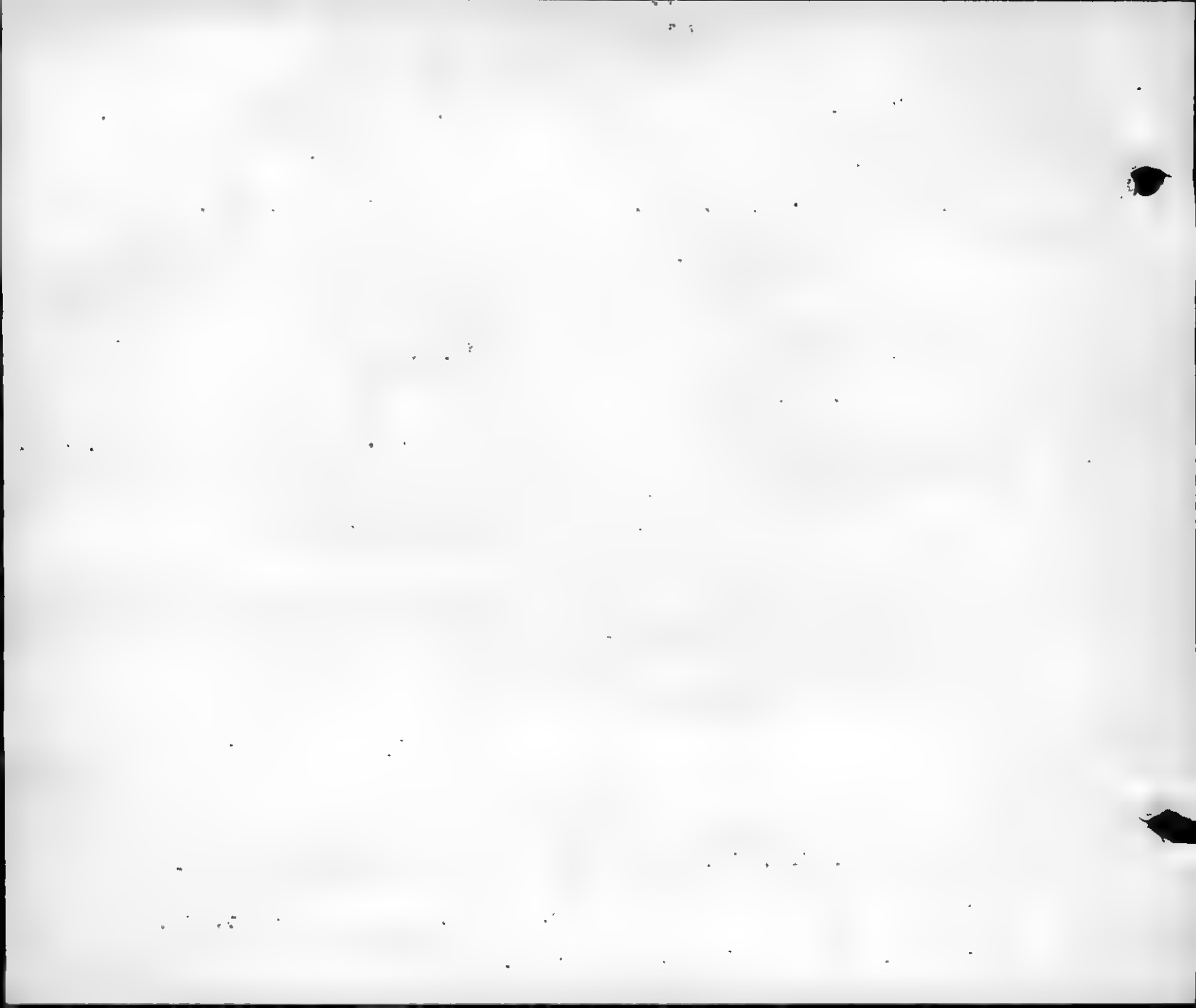
01699

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westview</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westview</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1333 Dillion Hgts. Ave.</b>				e. STREET ADDRESS <b>1333 Dillion Hgts. Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Helen M.</b> Middle <b>Nunnold</b> Last				4. DATE OF DEATH Month <b>2/1/60</b> Day Year <b>19</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/19/1883</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Joseph Goodman</b>			14. MOTHER'S MAIDEN NAME <b>Anna</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>George Nunnold</b>		INFORMANT Address <b>1333 Dillion Hgts. Ave.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Arteriosclerosis C.V. Disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>7 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Smoking</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June</b> , 19 <b>56</b> to <b>Feb 1</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan. 30</b> , 19 <b>60</b> , and that death occurred at <b>8 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Dr. D.C. McLaughlin</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Dr. D.C. McLaughlin</b>				<b>4508 Edmonson Ave.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/5/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>				ADDRESS <b>4107 Wilkens Ave. 29</b>		24a. REC'D BY REGISTRAR <b>FEB 4 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1555

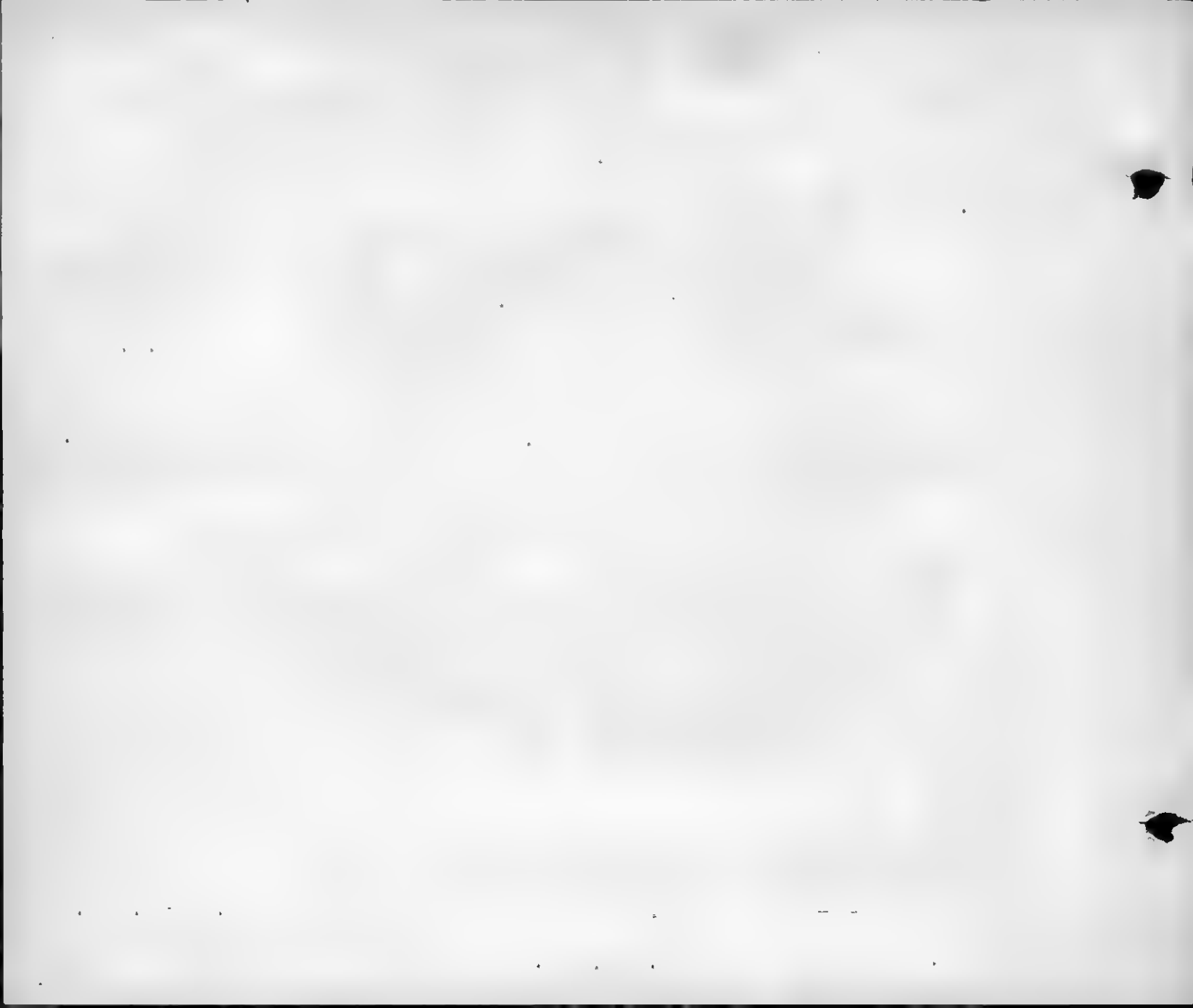
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> c. LENGTH OF STAY IN 1b <b>3 yr.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Res. 3101 Vulcan Road</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk</b> d. STREET ADDRESS <b>3101 Vulcan Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rose</b> Middle <b>Anna</b> Last <b>Oberholtzer</b>		4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>60</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 12, 1885</b>
9. AGE (In years last birthday) <b>74</b> yrs		10. IF UNDER 1 YEAR Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min.	11. IF UNDER 24 HRS Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lewis Krenz</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Weimer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give year or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Margaret Pearson</b>		Address <b>3101 Vulcan Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Influenza</b> 481X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Sclerotic Heart Disease</b> DUE TO (c) <b>Chronic Congestive Heart Failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days, 10 years,</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>Jan</b> Day <b>30</b> Year <b>1960</b> Hour <b>4:30</b> a. m. <b>PM</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 10, 1958</b> to <b>Feb 2, 1960</b> , that I last saw the deceased alive on <b>Jan 30, 1960</b> , and that death occurred at <b>4:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Roger G. Windsor, M.D.</b>		ADDRESS (Street, city or town, state) <b>520 St. Spenswood Rd, Baltimore 19, Md 21236</b>	
PHYSICIAN'S NAME (Type) <b>ROGER G. WINDSOR</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	22b. DATE THEREOF <b>2-5-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Bethel</b>	22d. LOCATION (City, town, or county) (State) <b>Columbia, Pa. Lanc. Co.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda</b>		ADDRESS <b>7922 Wise Ave. 22, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 4 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Knaus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



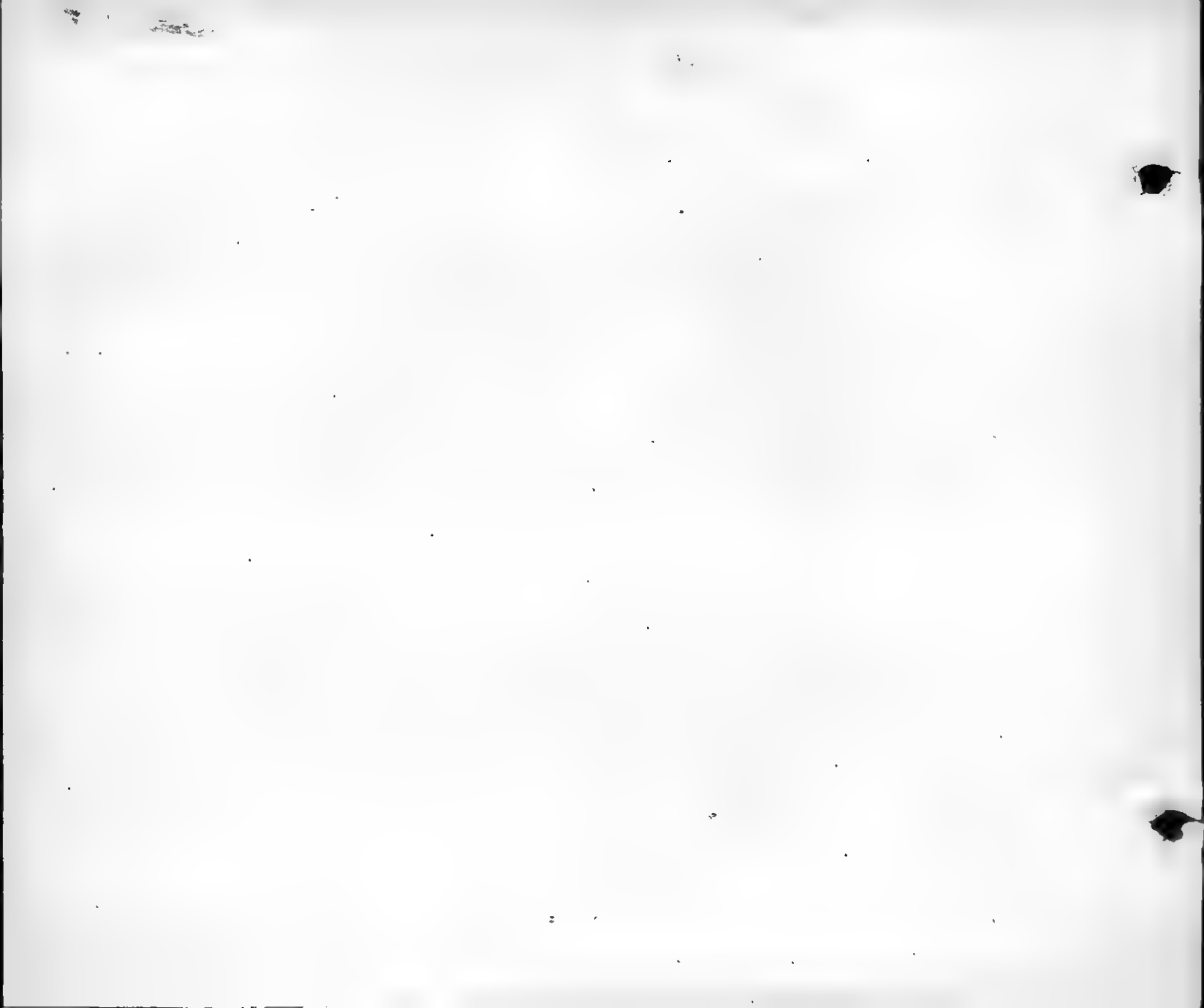
## 1713 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>62yr8mths</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Baltimore</b>	
f. STREET ADDRESS <b>234 South Bouldin Street</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Ott</b> Last <b>Ott</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>27</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1875 (?) AUG 27</b>
9. AGE (In years last birthday) <b>84</b> yrs.	10. IF UNDER 1 YEAR Months <b>8</b> Days <b>27</b> Hours <b>14</b> Min <b>4</b>	11. IF UNDER 24 HRS Months <b>8</b> Days <b>27</b> Hours <b>14</b> Min <b>4</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Cardiac failure</b> DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction chronic manic type</b> INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb. 17</b> , 1960, to <b>FEB 27</b> , 1960, that I last saw the deceased alive on <b>Feb 27</b> , 1960, and that death occurred at <b>9:55 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>2/29/60</b>			
ACTUAL SIGNATURE <b>Bruno Radauskas</b> M.D.		PHYSICIAN'S NAME (Type) <b>BRUNO RADAUSKAS</b> Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/29/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>John G. Connelly</b>	22d. LOCATION (City, town, or county) (State) <b>Taylor Ave. Balto Co.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Connelly</b>		24b. REC'D BY REGISTRAR DATE <b>MAR 2 '60</b>	24c. REGISTRAR'S SIGNATURE <b>Connelly S. Frank</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1714 CERTIFICATE OF DEATH

01702

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebbville</b>		c. LENGTH OF STAY IN 1b <b>73 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3207 Rolling Road</b>		e. STREET ADDRESS <b>3207 Rolling Road</b>	
3. NAME OF DECEASED (Type or print) <b>Celia</b>		4. DATE OF DEATH Month <b>February</b> Day <b>5</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 24, 1872</b>
9. AGE (In years last birthday) <b>87</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Andrew Askar</b>		14. MOTHER'S MAIDEN NAME <b>Eleanor Sank</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. J. Harry Subock</b>		Address <b>3207 Rolling Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion -</b> DUE TO <b>Hypertensive C.V. disease - arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>stroke - 2 per. cerebral vas. accidents -</b> DUE TO (c) <b>12 years</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 2, 1950</b> to <b>Feb 5, 1960</b> , that I last saw the deceased alive on <b>Feb 5, 1960</b> , and that death occurred at <b>7 A. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Thomas E. Wheeler</b> M.D. <b>3601 Clifmar Road Baltimore 7, Md.</b>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>Dr. Thos. E. Wheeler</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 8, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Randallstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers</b>		ADDRESS <b>8728 Liberty Rd. Randallstown</b>	
24a. REC'D BY REGISTRAR <b>FEB 12 '60</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



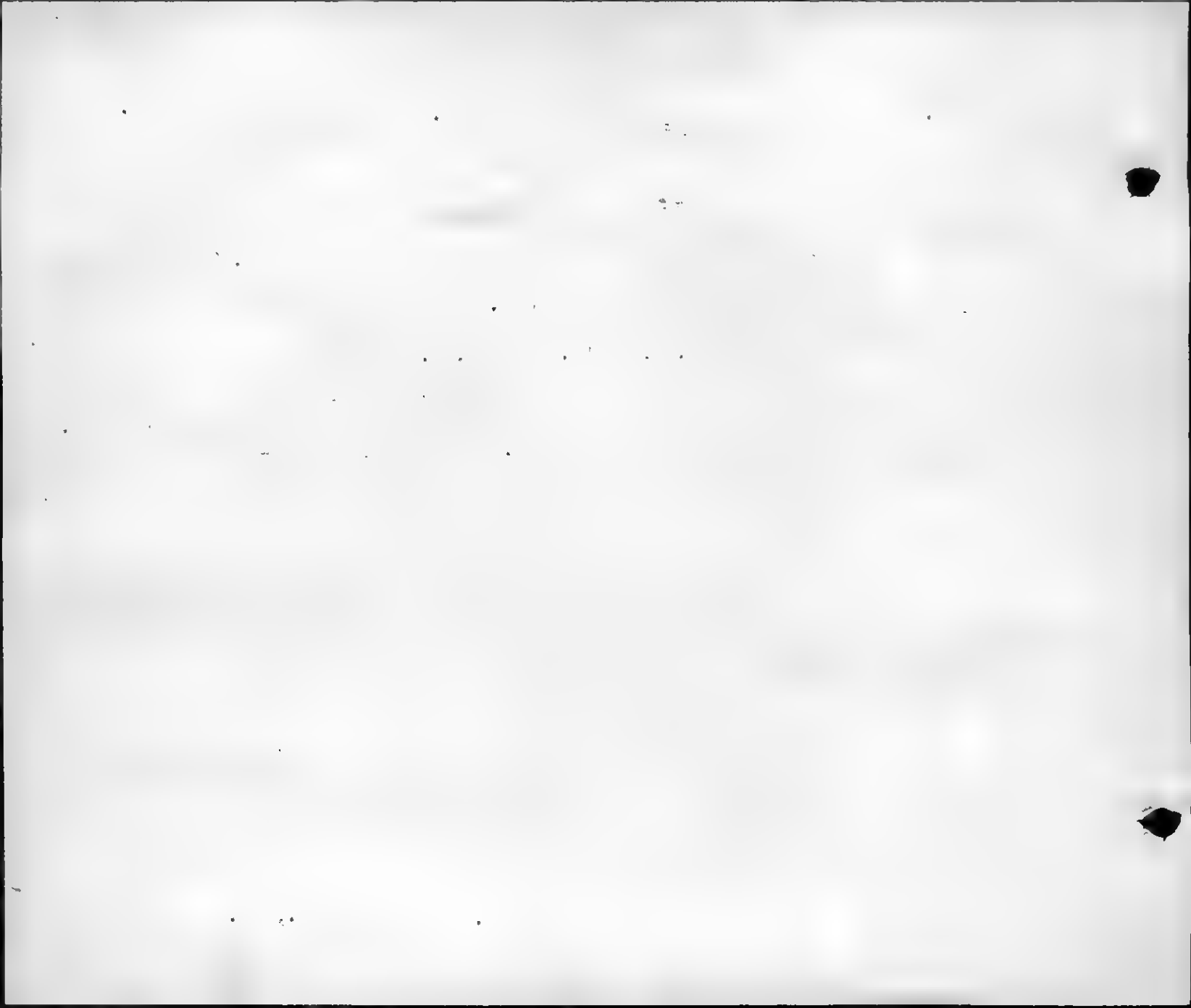
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01703

**1715 CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>				c. LENGTH OF STAY IN 1b <b>54</b> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2 Maple Drive</b>				e. STREET ADDRESS <b>2 Maple Drive</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN HALL PECK</b>			4. DATE OF DEATH Month Day Year <b>Feb. 25, 19 60</b>				
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 4, 1906</b>		9. AGE (In years last birthday) <b>54</b> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Industrial Specialist</b>			11b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Gov't.</b>		11. BIRTHPLACE (State or foreign country) <b>R. I.</b>		12. CITIZEN OF WHAT COUNTRY? <b></b>
13. FATHER'S NAME <b>Horace Sill Peck</b>				14. MOTHER'S MAIDEN NAME <b>Gertrude Tuller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Barbara White Peck - 2 Maple Drive</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RENAL INSUFFICIENCY</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CHRONIC PYELONEPHRITIS + NEPHROLITHIASIS, BILAT</b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>20 YRS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 19 49</b> to <b>Feb 25, 1960</b> , that (I) (we) lost saw the deceased alive on <b>Feb 25, 1960</b> , and that death occurred at <b>4:15 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Louis Semenov</b>				22b. DATE <b>2/26/60</b>		22c. PHYSICIAN'S NAME (Type) <b>LOUIS SEMENOFF</b>	
22d. ADDRESS <b>2108 OREMS RD, BALTO 20, MD</b>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22f. DATE <b>2/26/60</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>2/27/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crem.</b>		23d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tiekner &amp; Sons - Balto 17</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 29 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1564

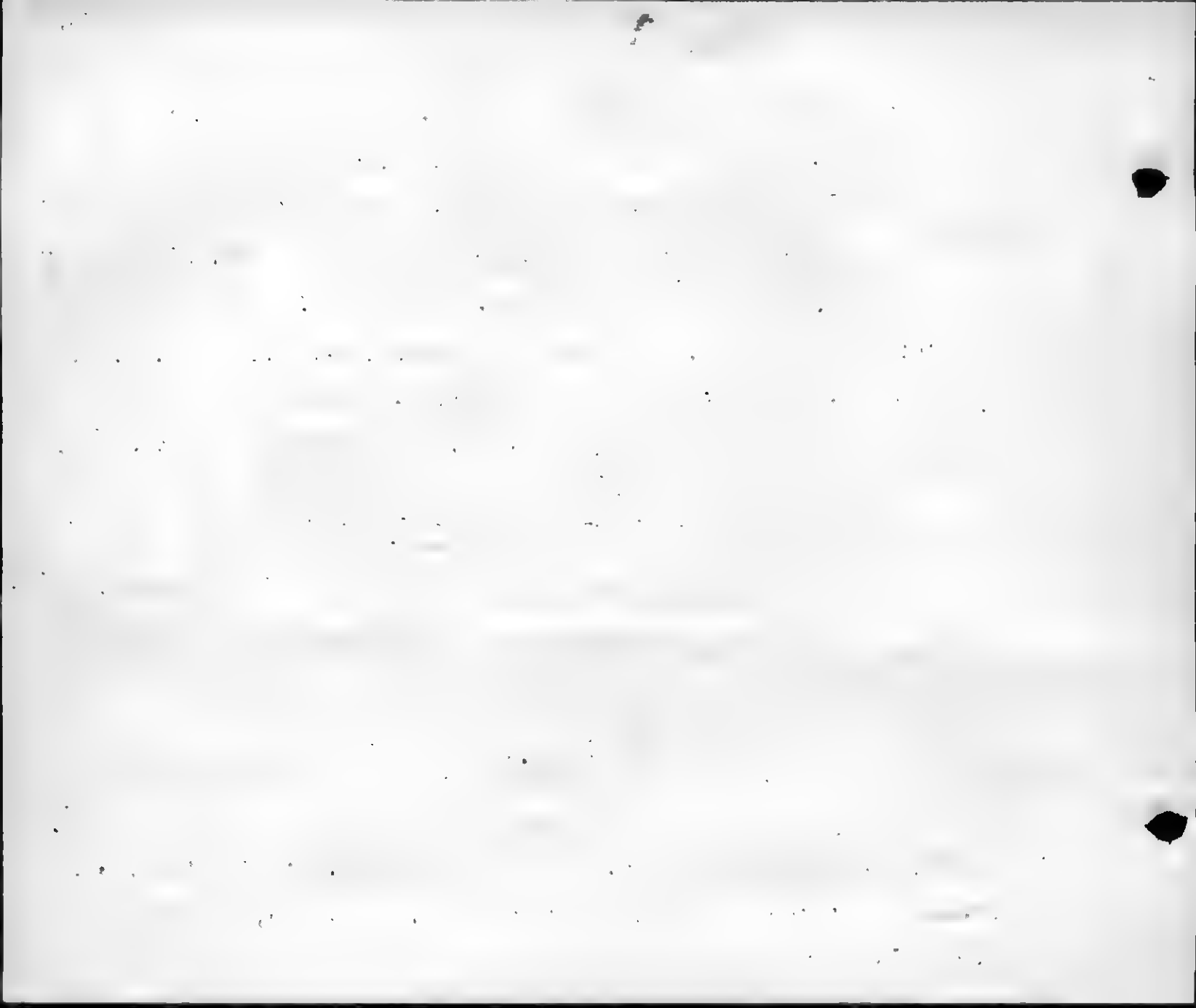
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>1821 Arbutus Avenue</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Halethorpe</b>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Emory</b> Last <b>Peddicord</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>26</b> Year <b>19 60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 25, 1888</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>3</b> Hours <b>14</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md. Dry Dock</b>	
11. BIRTHPLACE (State or foreign country) <b>Elkridge, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Elmer E. Peddicord</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Coates</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-01-6935</b>	
17. INFORMANT <b>Alice L. Peddicord</b>		Address <b>1821 Arbutus Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Chronic coronary artery disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Bronchitis</b> DUE TO <b>Chronic Bronchitis</b> (c) <b>Stenosed Aortic valve</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 mos 3 mos 14 ds</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Heart Failure</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 19 59</b> to <b>Feb 26 1960</b> , that I last saw the deceased alive on <b>Feb 25 1960</b> , and that death occurred at <b>1821</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bruce Brumbaugh</b> M.D.		ADDRESS (Street, city or town, state) <b>5609 Main Street Elkridge, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Bruce Brumbaugh, M.D.</b>		5609 Main Street Elkridge, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/29/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Grace Episcopal Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Elkridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Avenue</b>	
24a. REC'D BY REGISTRAR <b>FEB 29 1960</b>		DATE	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

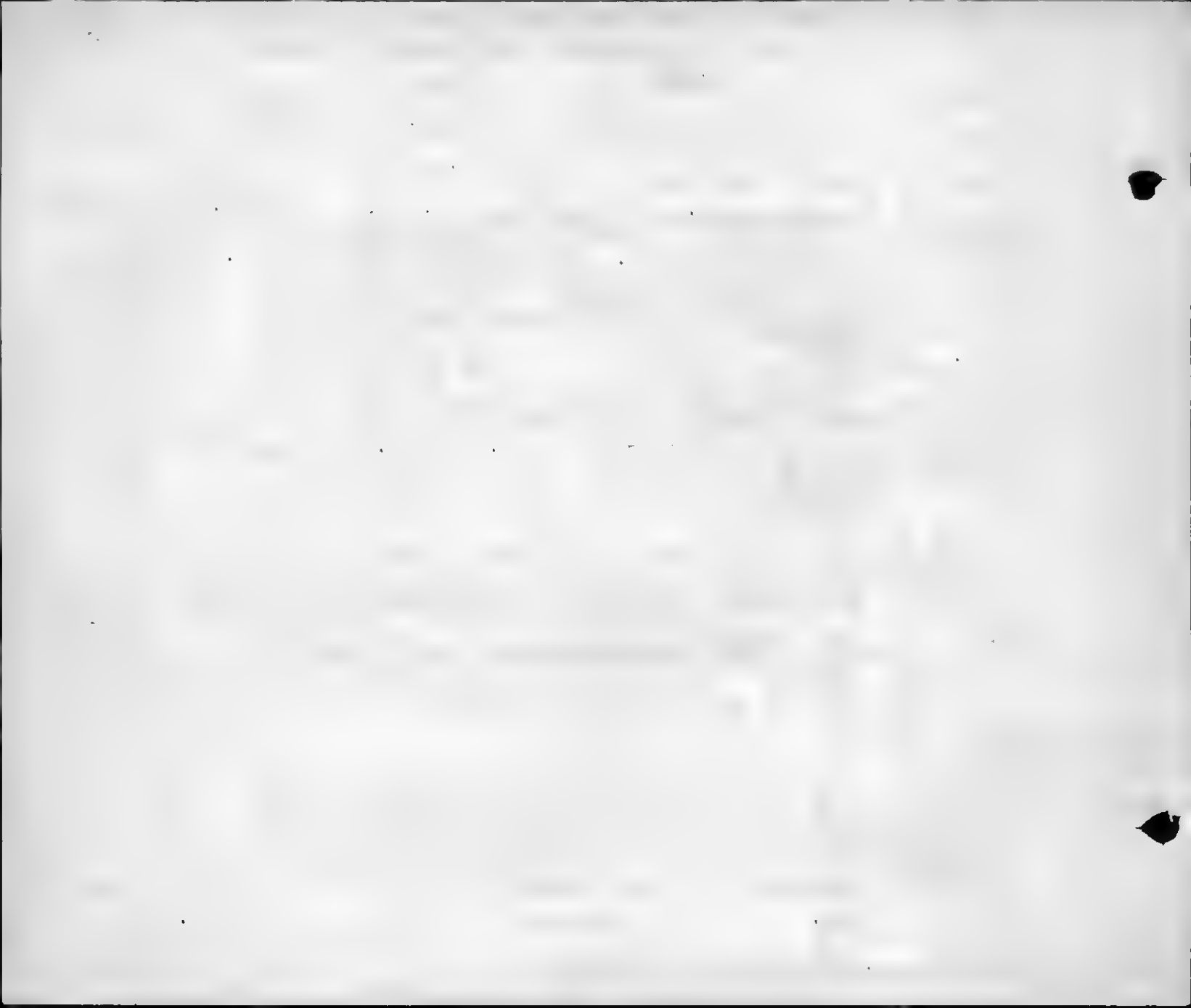
01705

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">1715</span> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1741 Glen Ridge Rd.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u> d. STREET ADDRESS <u>1741 Glen Ridge Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Walter E. Perkins</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Feb. 1, 1960</u>											
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>July 5, 1888</u>		<b>9. AGE</b> (in years last birthday) <u>71</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Ret. Colonel</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>USA</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Kentucky</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>					
<b>13. FATHER'S NAME</b> <u>Unknown</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>215-34-5379</u>		<b>17. INFORMANT</b> Address <u>Mrs. Mary M. Perkins, 1741 Glenridge</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation</u> <u>174x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____												INTERVAL BETWEEN ONSET AND DEATH			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <u>Depression</u>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
<b>ACTUAL SIGNATURE</b> <u>John C. Hyle</u>						<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>						<b>DATE SIGNED</b> <u>2-2-60</u>			
<b>EXAMINER'S NAME (Type)</b> <u>JOHN C. Hyle</u>						<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>burial</u> <b>22b. DATE THEREOF</b> <u>Feb. 5, 1960</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington Nat'l</u> <b>22d. LOCATION (City, town, or county)</b> <u>Arlington, Va.</u> (State)									
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Leonard J. Ruck 5305 Harford Rd</u>						<b>24a. REC'D BY REGISTRAR</b> <u>FEB 5 1960</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the registrar prior to burial, cremation, or removal.





## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1717

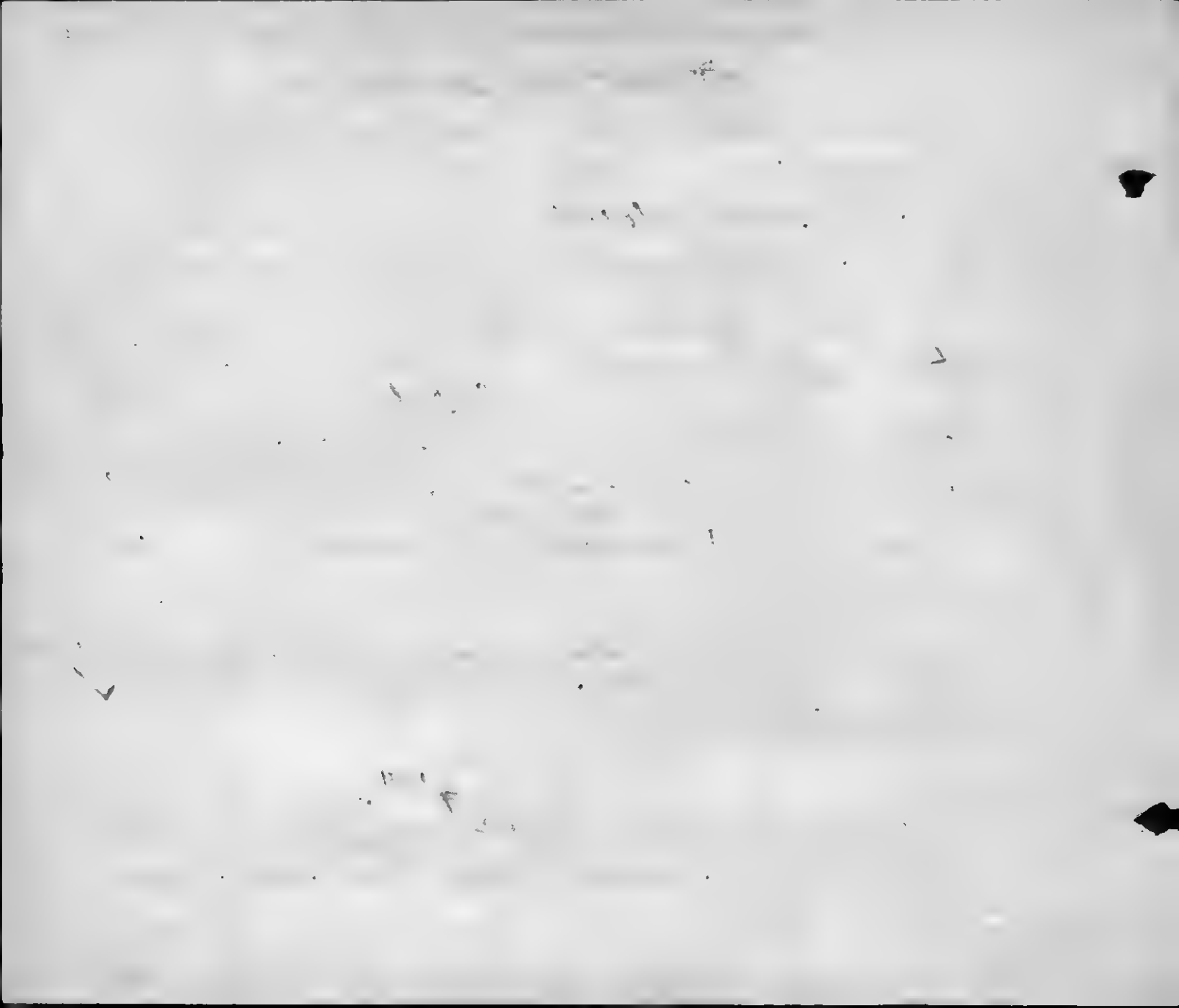
1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore County</u>	MARYLAND	STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mt. Wilson, Maryland</u>	LENGTH OF STAY (in this place) <u>11 months</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ANNAPOLIS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>		STREET ADDRESS (If rural give location) <u>1023 MADISON STREET</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>FRANK VINCENT PHIPPS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2-29-1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>7/9/17</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MUSIC MACHINE MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>HORACE E. PHIPPS</u>		14. MOTHER'S MAIDEN NAME <u>BEULAH JOHNSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-14-2090</u>	
17. INFORMANT & ADDRESS <u>Hospital Records, Mt. Wilson State Hospital</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
02x IMMEDIATE CAUSE (A) <u>PULMONARY TUBERCULOSIS</u>			<u>2 1/2 yrs.</u>
ANTECEDENT CAUSE(S) DUE TO (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>ENLARGEMENT OF HEART due to PULMONARY DISEASE 1 YEAR</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3/10</u> , 19 <u>59</u> , to <u>2/29</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/29</u> , 19 <u>60</u> , and that death occurred at <u>1230 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Wm. Newcomer</u>		ADDRESS (Street, city, town, state) <u>Wm. Newcomer, M.D. Superintendent, Mt. Wilson, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>3-3-60</u>	NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>	LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>
24. REC'D BY REGISTRAR <u>MAR 3 60</u>	REGISTRAR'S SIGNATURE <u>C. L. S. Kraus</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Sons</u>	ADDRESS <u>1111 North 1st St. Md.</u>

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M



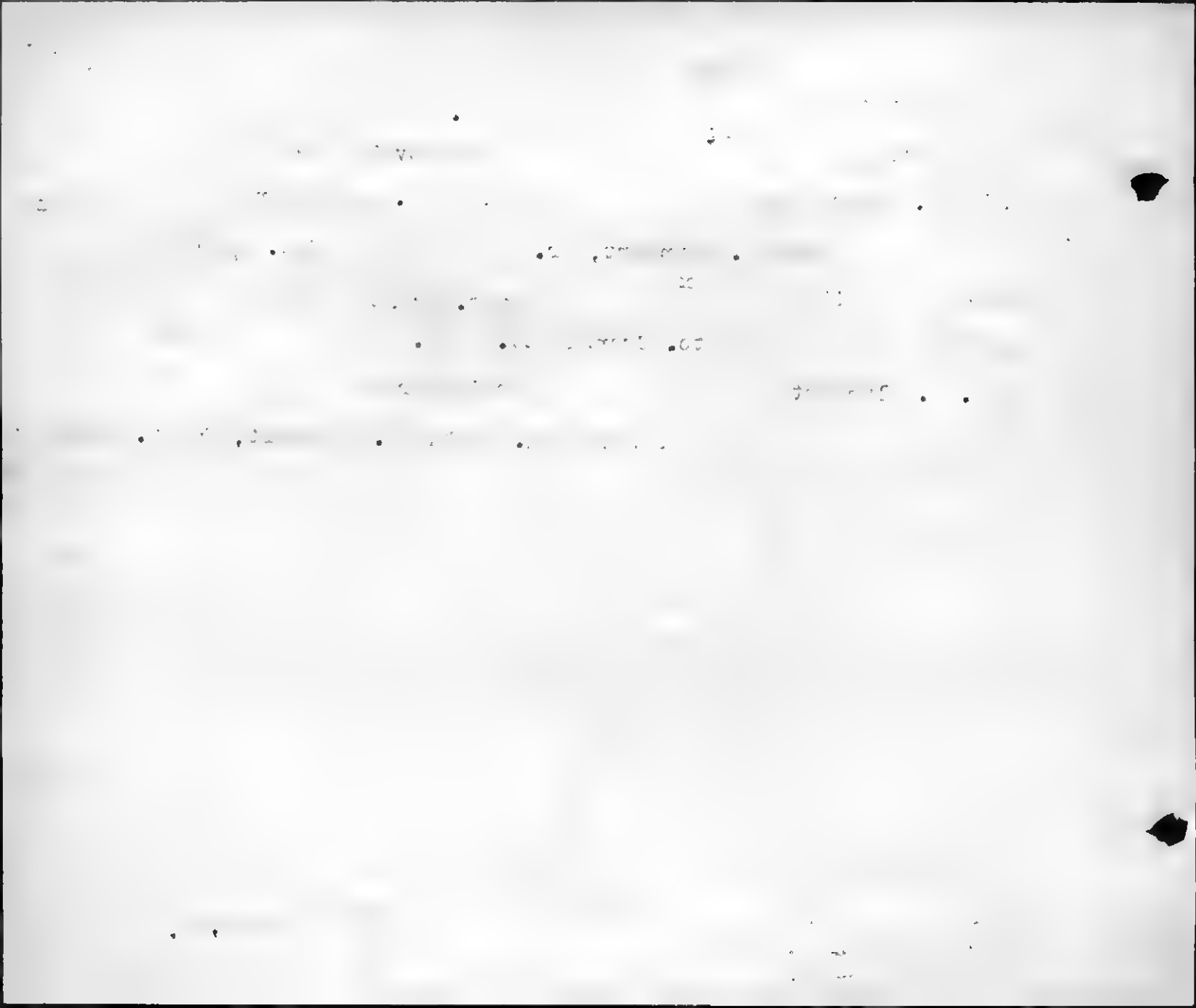
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) <b>970 St. Agnes Lane</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Ma.</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville 28</b> d. STREET ADDRESS <b>970 St. Agnes Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James H.</b> Middle <b>Plunkert,</b> Last <b>Sr.</b>		4. DATE OF DEATH <b>Feb. 6/60</b> Day <b>19</b> Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 29/92</b> 9. AGE (In years last birthday) <b>67</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Transit Co. Md.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Geo. W. Plunkert</b>		14. MOTHER'S MAIDEN NAME <b>Louisa Krah</b>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. <b>215 09 3816</b>	
17. INFORMANT <b>Mrs. Bertha E. Plunkert,</b> Address <b>970 St. Agnes Lane</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Arteriosclerotic cardiovascular disease.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>diase.</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/10</b> , 19 <b>59</b> to <b>2/6</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>2/6</b> , 19 <b>60</b> , and that death occurred at <b>7:00</b> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arthur M. Krueger</b>		ADDRESS (Street, city or town, state) <b>2108 Eutaw Place</b> DATE SIGNED <b>2/7/60</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/9/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore 29 Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors</b> <b>4101 Edmondson Ave</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 9 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01708

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

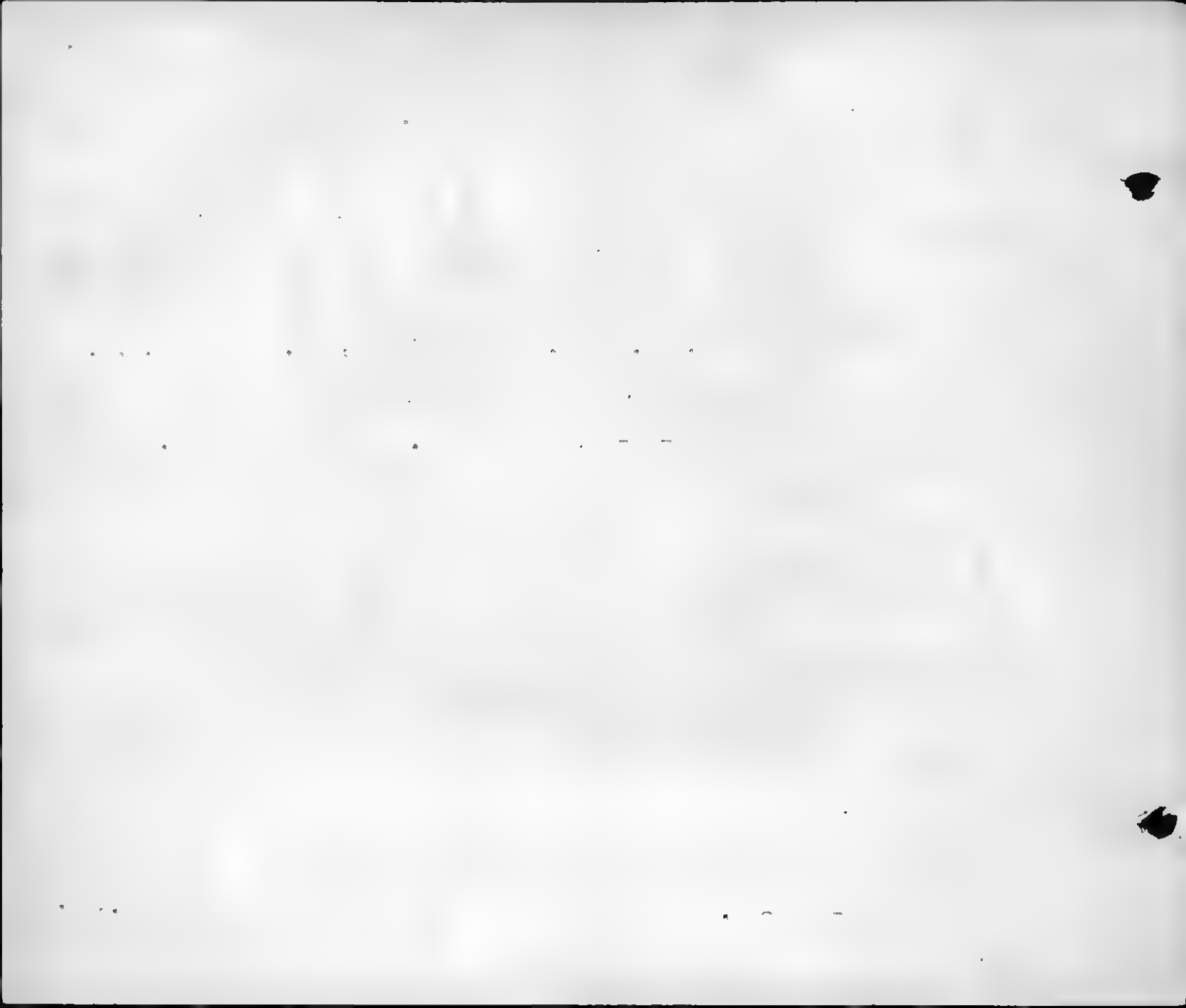
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <span style="float: right;">1719</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eastwood</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7260 Stratton Way # 24</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eastwood</b> d. STREET ADDRESS <b>7260 Stratton Way</b> e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOSEPH GEORGE PODRAZA</b>		4. DATE OF DEATH Month <b>February</b> Day <b>21</b> Year <b>1960.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 24-07</b>
9. AGE (In years last birthday) <b>52</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stevendore</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph PODRAZA</b>	
14. MOTHER'S MAIDEN NAME <b>EVA KOE</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO <b>217-05-7511</b>		17. INFORMANT <b>Annette V. Podraza</b> Address <b>Same.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO (b) <b>Hypertension - CV Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>NONE</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M. B. Davis</b>		DATE SIGNED <b>2/22/60</b>	
EXAMINER'S NAME (Type) <b>M. B. DAVIS MD.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-24-60.</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>7401 German Hill Rd., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Zeller</b>		ADDRESS <b>901 S. CONKLING ST. BALTO., MD.</b>	
24a. REC'D BY REGISTRAR <b>DATE FEB 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, the certificate should be executed within 72 hours of death. If any delay is necessary, the certificate should be executed within 72 hours of death. If any delay is necessary, the certificate should be executed within 72 hours of death.

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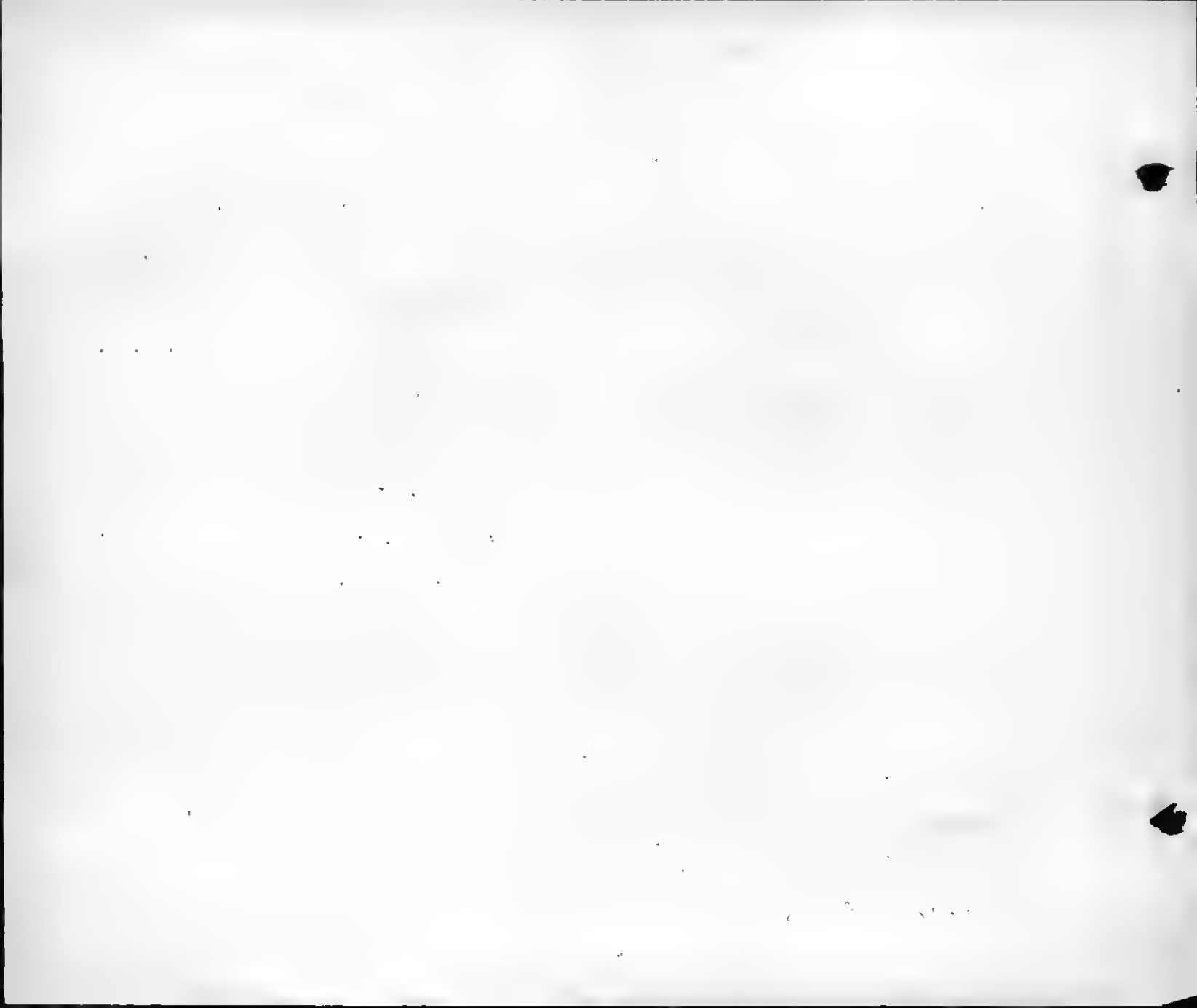
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1720 CERTIFICATE OF DEATH

Reg. Dist. No.

01789

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Y</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>13yr5mth18dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Preller</b> Last <b>Preller</b>		4. DATE OF DEATH Monthly <b>Feb.</b> Day <b>11</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1890</b>
9. AGE (In years last birthday) <b>69</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Andrew Preller</b>		14. MOTHER'S MAIDEN NAME <b>Mary A. Gaff</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>	
INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia, terminal</b> 422.1 DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>Generalized Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1-2 wks</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 30, 1960</b> to <b>Feb. 11, 1960</b> , that I last saw the deceased alive on <b>Feb. 11, 1960</b> , and that death occurred at <b>6:25 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edward T. Schnoor</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>2-11-60</b>	
PHYSICIAN'S NAME (Type) <b>Edward T. Schnoor, M.D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATON, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>Feb 15, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO. Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY W JENKINS &amp; SONS CO</b>		ADDRESS <b>4905 York</b>	
24a. REC'D BY REGISTRAR <b>FEB 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

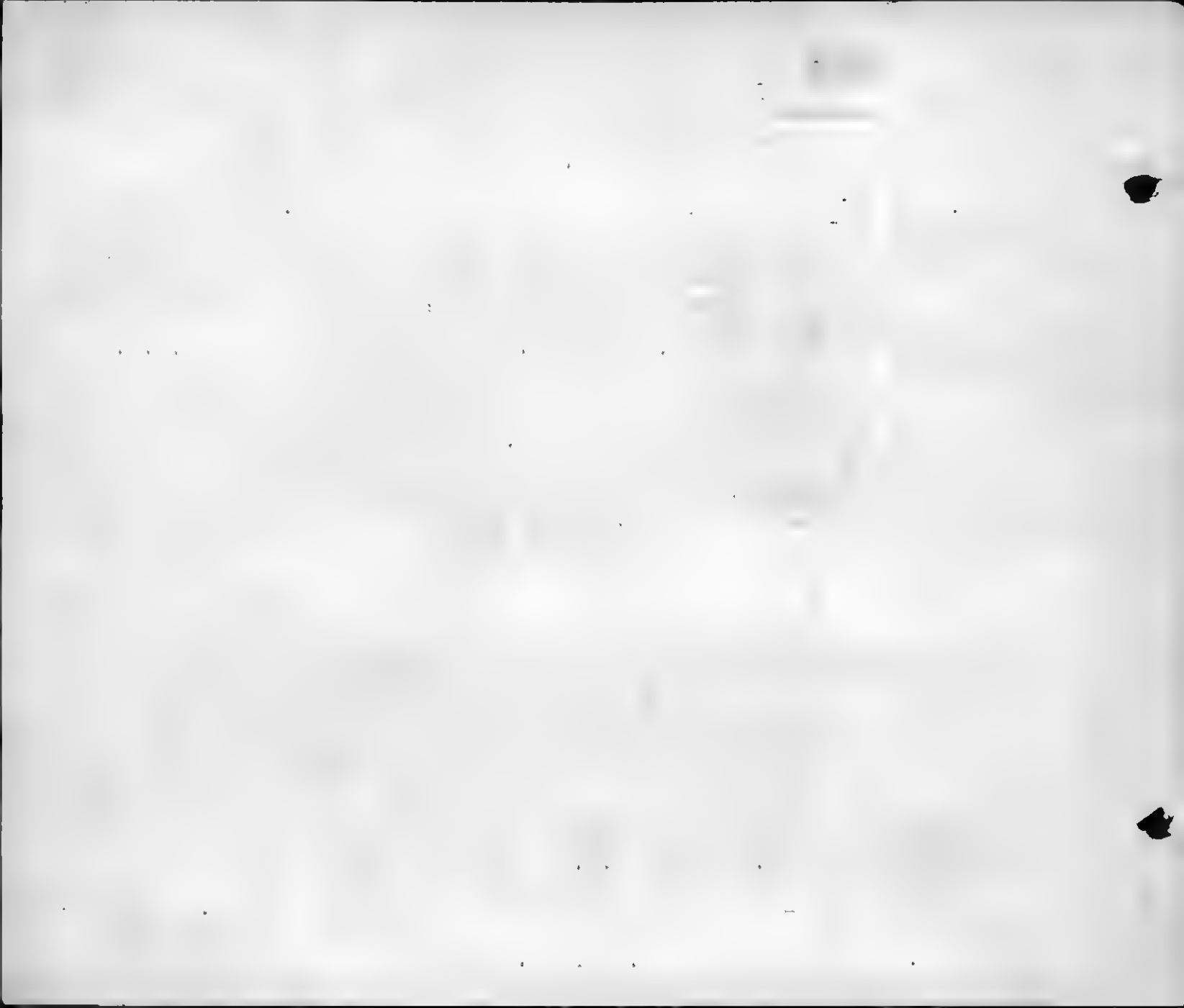
Reg. Dist. No. 01710

1556

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Dundalk</u> <u>Pitman</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm sion) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b <u>40 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Res., 21 Admiral Blvd.</u>			d. STREET ADDRESS <u>21 Admiral Blvd.</u>		
3. NAME OF DECEASED (Type or print) <u>Frank</u> <u>Thomas</u> <u>Ramsey</u>			4. DATE OF DEATH Month <u>February</u> Day <u>25</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28, 1902</u>	9. AGE (In years last birthday) <u>57</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Thomas Ramsey</u>		
14. MOTHER'S MAIDEN NAME <u>Anna ???</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		
16. SOCIAL SECURITY NO. <u>213-07-8973</u>			17. INFORMANT <u>Mrs. Thelma Schuman</u> Address <u>6120 Shipview Way 24</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>					
4 <u>  </u> DUE TO (b) <u>Hypertensive Cardio-Vascular Disease</u>					
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>  </u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) <u>  </u>	(County) <u>  </u>	(State) <u>  </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>M. B. Davis</u>		EXAMINER'S NAME (Type) <u>Melvin B. Davis, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-29-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	
22d. LOCATION (City, town, or county) <u>Eastern Blvd.</u>		(State) <u>Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Duda</u>			ADDRESS <u>7922 Wise Ave. 22, Md.</u>		
24c. REC'D BY REGISTRAR DATE <u>FEB 29 '60</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY REGISTRAR: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

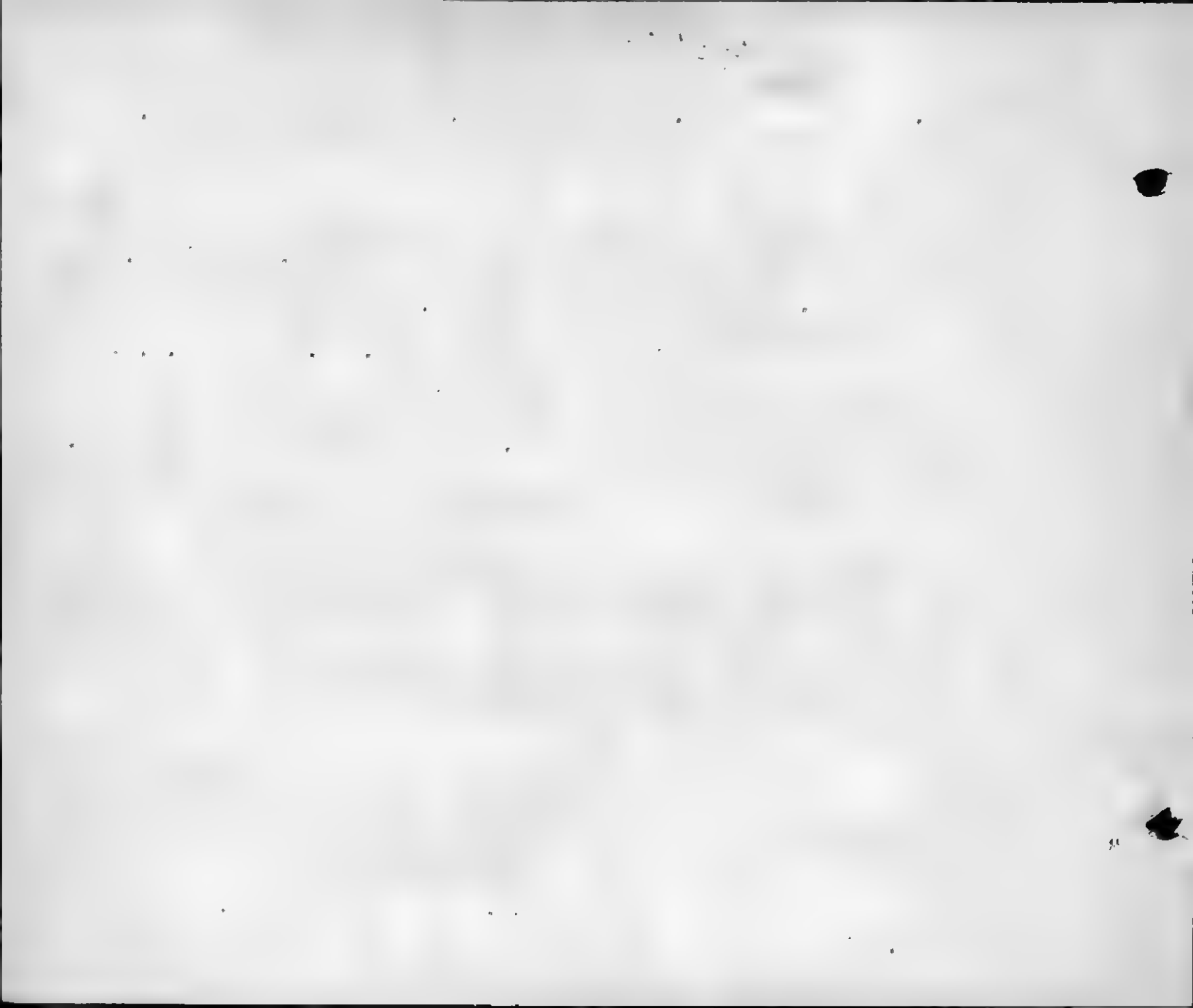
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>?</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>10 Robinson Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Rincoldia Ranson</b>		4. DATE OF DEATH Month Day Year <b>Feb. 16th. 19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 10th. 1910</b>
9. AGE (In years last birthday) <b>49</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Essix Co. Va.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Skipmore Young</b>	
14. MOTHER'S MAIDEN NAME <b>Annie Ransing</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT Address <b>Rev. Shirley Ranson 10 Robinson Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CA of Breast</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>170 X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>JACK C COLLINS</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JACK C COLLINS</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/19/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt Calvery Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Brooklyn Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy O. Wilson</b>		24. REC'D BY REGISTRAR <b>DATE</b>	
25. REGISTRAR'S SIGNATURE		26. REGISTRAR'S SIGNATURE	



## 1721 CERTIFICATE OF DEATH

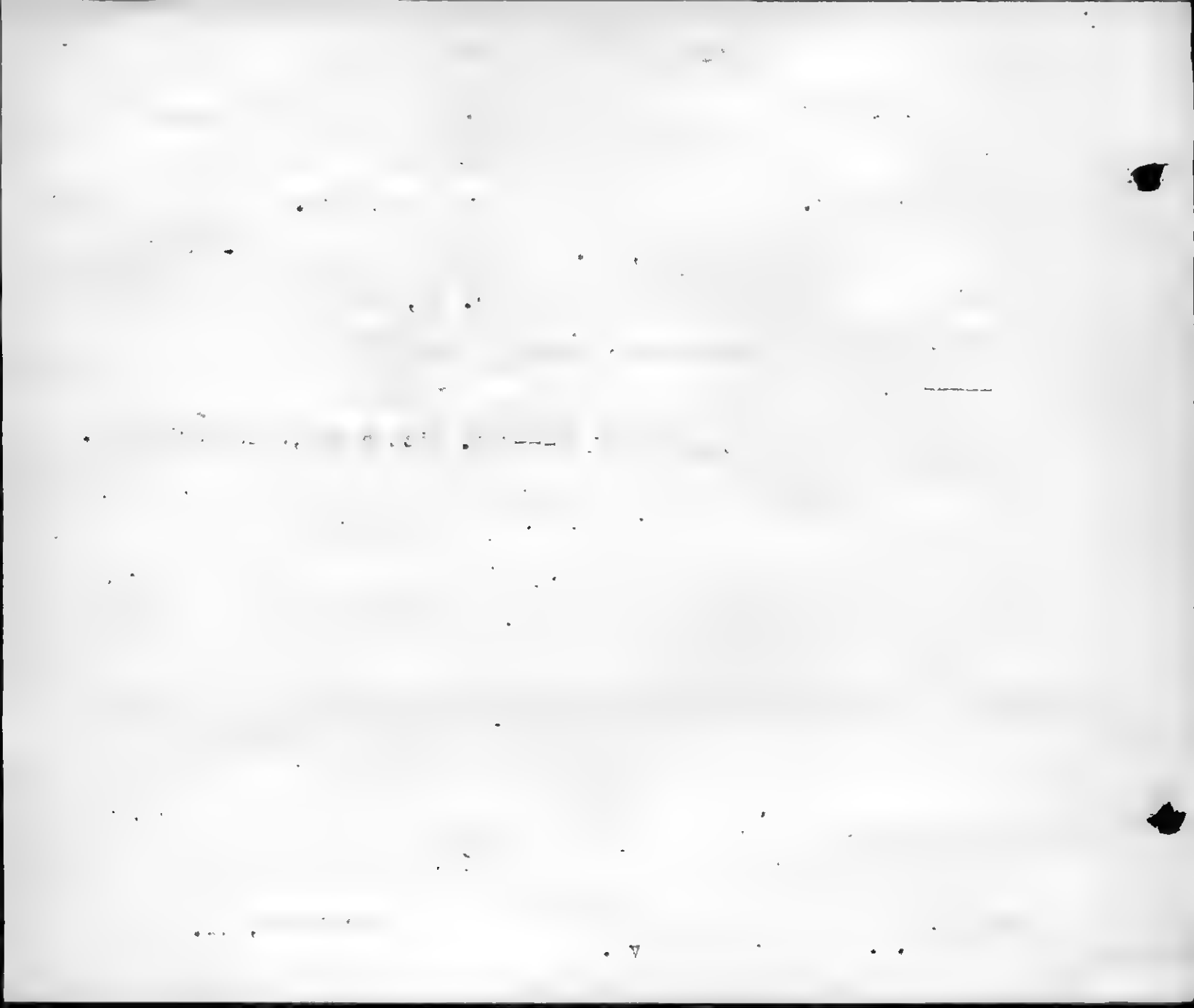
Reg. Dist. No.

01712

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Res. dence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5619 North Ave.</b>		d. STREET ADDRESS <b>5619 North Ave.</b> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Ray</b> Last <b>Sr.</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>29</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 24, 1886</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min.	11. IF UNDER 24 HRS Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when retired) <b>Retired Packer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Commission House</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ray</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>216 07 1521 A</b>	
17. INFORMANT <b>Mrs. Lizzie Ray</b>		Address <b>5619 North Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> DUE TO <b>myocardial infarction</b> (b) <b>arteriosclerosis</b> DUE TO <b>hypertension</b> (c) <b>atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>17 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 10, 1959</b> to <b>Feb 29, 1960</b> that I last saw the deceased alive on <b>Feb 29, 1960</b> , and that death occurred at <b>5619 North Ave.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>DR R. D. Edmondson</b>		DATE SIGNED <b>MAR 3 1960</b>	
PHYSICIAN'S NAME (Type) <b>DR R. D. Edmondson</b>		ADDRESS <b>5619 North Ave.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 3/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Louden Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F.D. 4101 Edmondson Ave.</b>		24a. REC'D BY REGISTRAR <b>Mar 3 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles E. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1722

## CERTIFICATE OF DEATH

Reg. Dist. No.

01713

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Monkton</u>				c. LENGTH OF STAY IN 1b <u>45 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Hutchins Mill Road</u>			
3. NAME OF DECEASED (Type or print) <u>MARTHA WALSH REICHERT</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 19, 1872</u>		9. AGE (In years last birthday) <u>87</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Long Green, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Patrick Walsh</u>				14. MOTHER'S MAIDEN NAME <u>Mary Roach</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Fredrick Reichert</u> Address <u>Monkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-15</u> , 19 <u>60</u> , to <u>2-18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-17</u> , 19 <u>60</u> , and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Herbert Mueller Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>YORK RD. PARKTON MD</u> DATE SIGNED <u>2/18/60</u>			
PHYSICIAN'S NAME (Type) <u>C. Herbert Mueller Jr.</u>				Parkton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/20/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Good Will</u>		22d. LOCATION (City, town, or county) (State) <u>Rutledge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Kurtz</u>				ADDRESS <u>Farmersville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 23 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. C. Kurtz</u>			

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

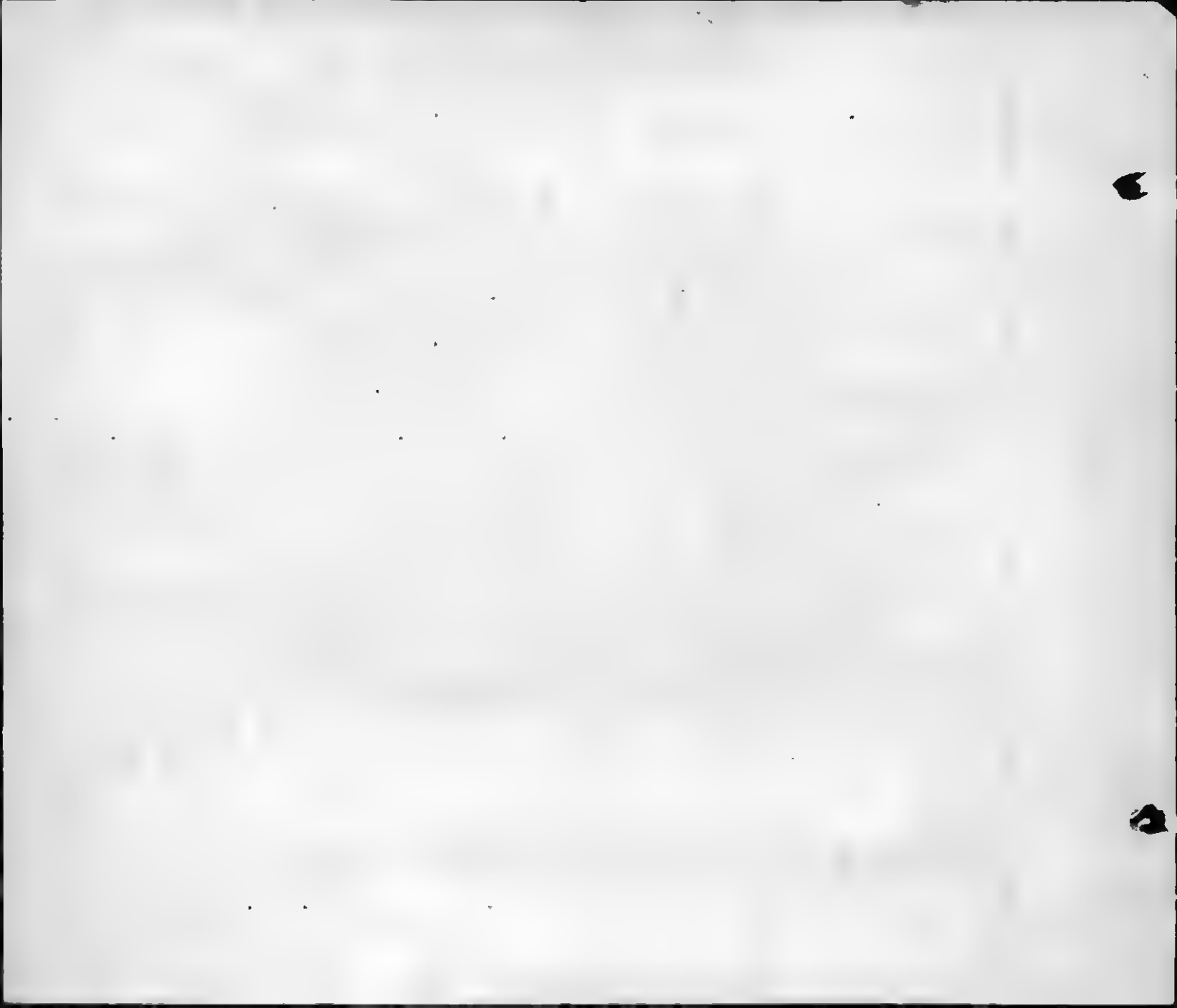
## 1723 CERTIFICATE OF DEATH

Reg. Dist. No.

01714

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>1</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines</b>				d. STREET ADDRESS <b>4412 Belvieu Ave.</b>			
3. NAME OF DECEASED (Type or print) <b>Sarah Ann Ringer</b>				4. DATE OF DEATH Month <b>2</b> Day <b>10</b> Year <b>1960</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 30, 1873</b>	9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Richard Geoghegan</b>				14. MOTHER'S MAIDEN NAME <b>Laura V. Salgee</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>none</b>		17. INFORMANT <b>Mrs. Emily J. Snyder - 8436 Church Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Ischemia</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Hypertensive Cardiac-Vascular Disease</b> DUE TO (c) <b>13 yr.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>12-29-1959</b> , to <b>2-10-1960</b> , that I last saw the deceased alive on <b>2-10-1960</b> , and that death occurred at <b>10:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wilmer K. Gallagher</b>				ADDRESS (Street, city or town, state) <b>6209 Frederick Ave</b>			
PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher</b>				DATE SIGNED <b>2-10-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/13/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thos. J. Dickner &amp; Sons - Balto. 17th</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

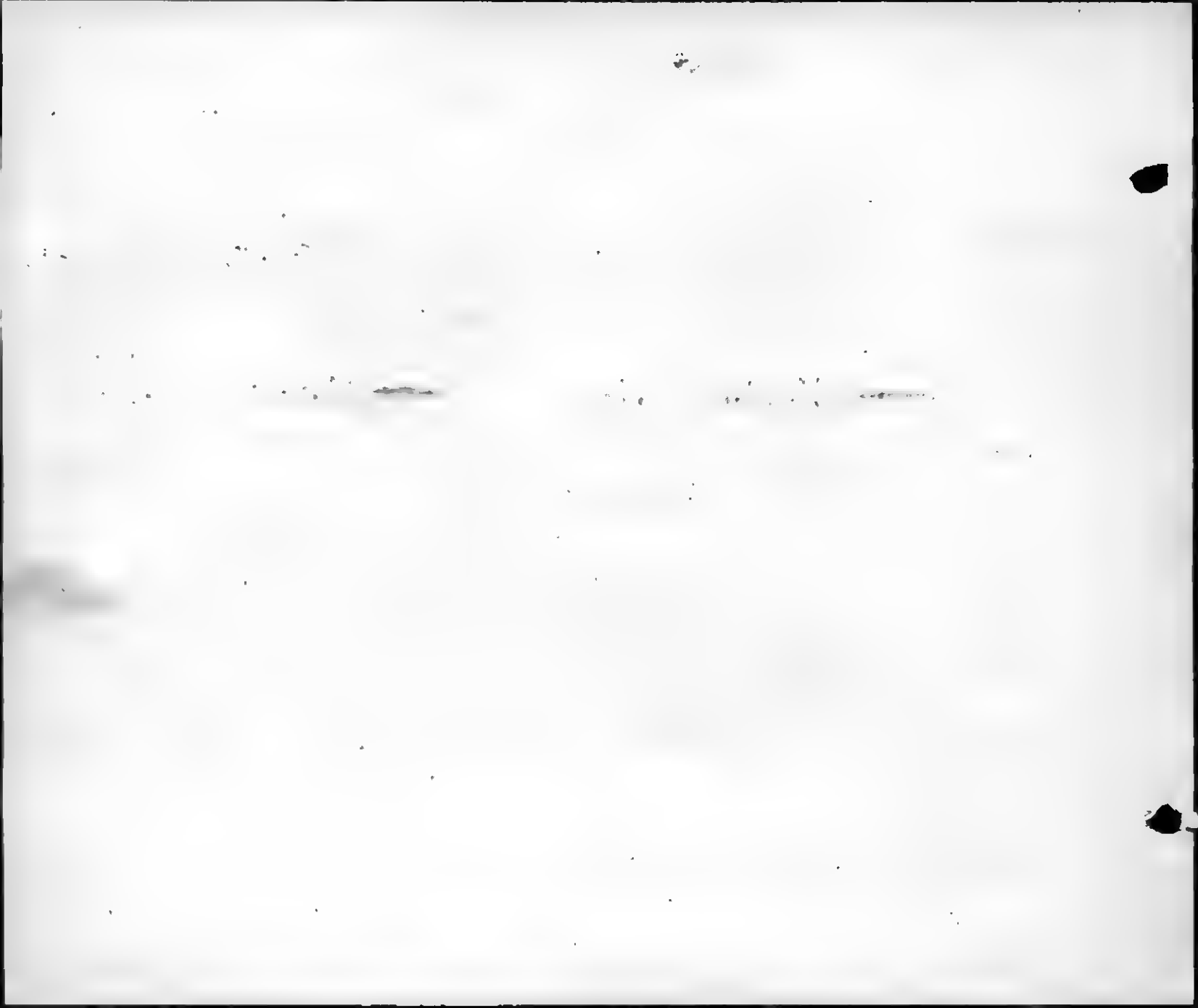
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>19 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mrylabd</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b> d. STREET ADDRESS <b>6790 Baltimore Blvd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Milton</b> Middle <b>Orville</b> Last <b>Robey</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>17</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 22, 1890</b>
9. AGE (In years last birthday) <b>69</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>odd jobs</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Milton Robey</b>	
14. MOTHER'S MAIDEN NAME <b>Mattie Clements</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cardiac failure</b> (c) <b>Anteriol. Cardiovasc. Disease</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb. 5, 1960</b> to <b>Feb. 17, 1960</b> , that I last saw the deceased alive on <b>February 17, 1960</b> , and that death occurred at <b>6:25 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D.		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>2/17/60</b>	
PHYSICIAN'S NAME (Type) <b>STELLA WACHSLER</b>		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/20/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Burial Park</b>	22d. LOCATION (City, town, or county) <b>Pennock</b> (State) <b>Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harold E. General</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 24 '60</b>	
ADDRESS <b>Waldorf Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kneass</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



## 1725 CERTIFICATE OF DEATH

Reg. Dist. No.

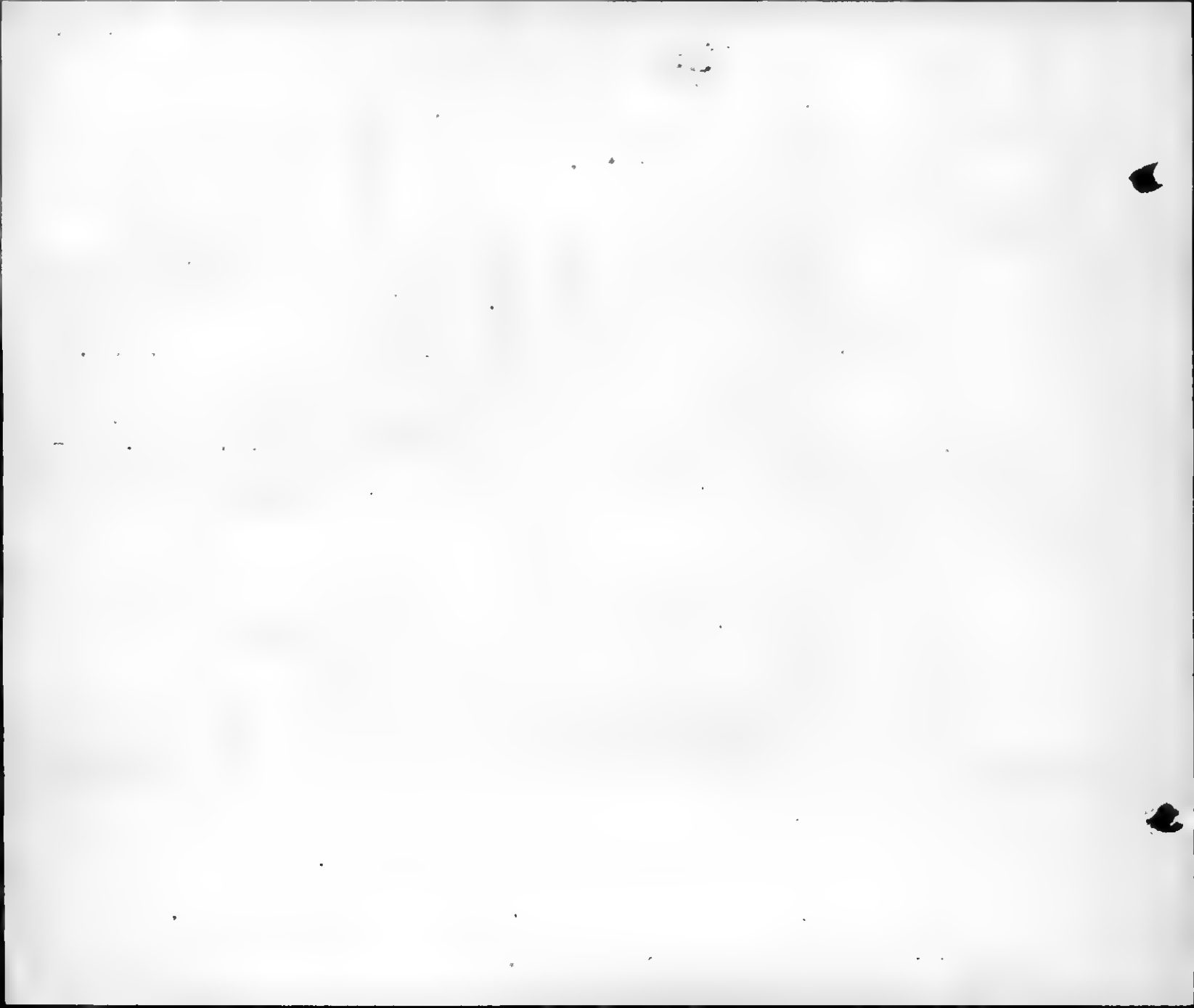
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>44 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rockwell Avenue</b>		e. STREET ADDRESS <b>Rockwell Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Emilie</b> Middle <b>Rockstroh</b> Last		4. DATE OF DEATH Month <b>Feb.</b> Day <b>22</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 1, 1885</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Daniel Flugard</b>		14. MOTHER'S MAIDEN NAME <b>Augusta Raduhn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Albert Rockstroh</b>		Address <b>28, Md. Rockwell Ave. Catonsville -</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Systemic Arteriosclerosis Dissect</b> INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/20, 1957</b> , to <b>2/22, 1960</b> , that I last saw the deceased alive on <b>2/12, 1960</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1047 Ingleside Ave (28)</b> DATE SIGNED ACTUAL SIGNATURE <b>Max J. Miller M.D.</b> M.D. <b>Baltimore Md</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/25/1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Salem Lutheran Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Catonsville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Sons</b>		24a. REC'D BY REGISTRAR <b>FEB 26 1960</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hearn</b>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



1726

## CERTIFICATE OF DEATH

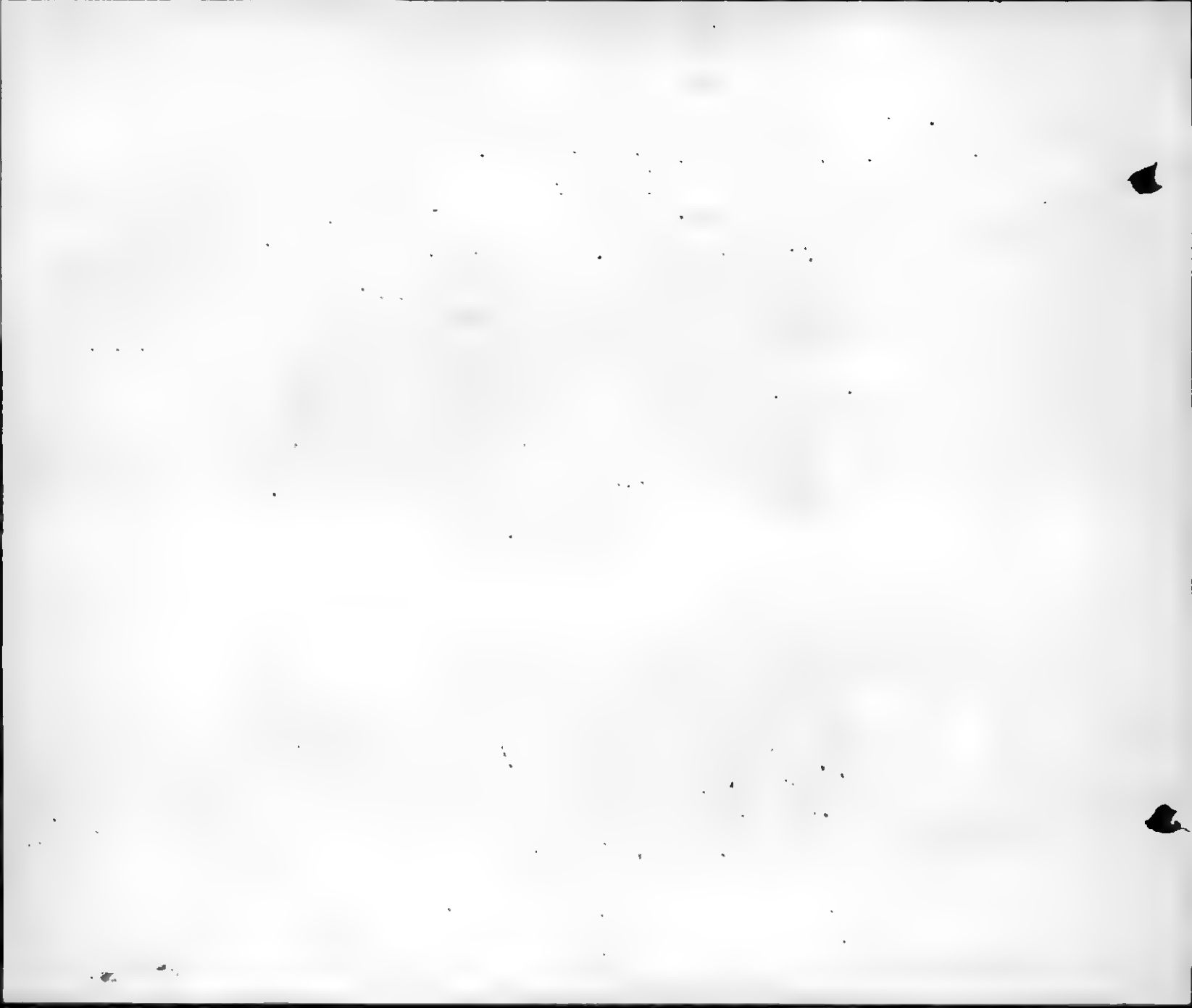
01717

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Summit Nursing Home Smithwood and Summit Aves.</u>		d. STREET ADDRESS <u>203 E. Lafayette Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Nannie</u> Middle <u>F.</u> Last <u>Rose</u>		4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>April 25, 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas W. Rose</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Tolley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
INFORMANT Address <u>Mrs. Madeline Hashagen, 1221 Woodbourne Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>434.1</u> DUE TO <u>Pulmonary Edema Acute congestive Heart Failure Acute &amp; chronic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>June 1958</u> to <u>2/17/60</u> , that I last saw the deceased alive on <u>2/17/60</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. E. Mc Grath M.D.</u>		ADDRESS (Street, city or town, state) <u>1303 Frederick Rd Catonsville, Md</u> DATE SIGNED <u>2/18/60</u>	
PHYSICIAN'S NAME (Type) <u>W. E. Mc Grath M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2-22-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Elkridge, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook Inc.</u> ADDRESS <u>1217 St. Paul St. Baltimore</u>		24a. REC'D BY REGISTRAR <u>  </u> DATE <u>FEB 23 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>  </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





14  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0-718

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6109 Windsor Mill Road</b>		d. STREET ADDRESS <b>6109 Windsor Mill Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>OSIE D. RUTTER</b>		4. DATE OF DEATH <b>February 25 1960</b>		5. SEX <b>Female</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 11, 1896</b>	
9. AGE (In years, last birthday) <b>#63</b>		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hrs. <input type="checkbox"/> Mins. <input type="checkbox"/>		11. IF UNDER 24 HRS.: Hours <input type="checkbox"/> Mins. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Davis West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Arthur J. Ervin</b>		14. MOTHER'S MAIDEN NAME <b>Viola G. Hill</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Edward L. Rutter</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary thrombosis, acute</b> 2+ ) DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause first. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>6109 Windsor Mill Road</b>	
20f. (City or town) <b>Woodlawn</b>		20g. (County) <b>Baltimore</b>		20h. (State) <b>Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>W. Bradley King, Jr., M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2/26/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-29-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	
22d. LOCATION (City, town, or country) <b>Woodlawn, Maryland</b>		22e. (State) <b>Maryland</b>		22f. (County) <b>Baltimore</b>	
23. FUNERAL DIRECTOR <b>Ellsworth Armacost, Baltimore, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 29 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



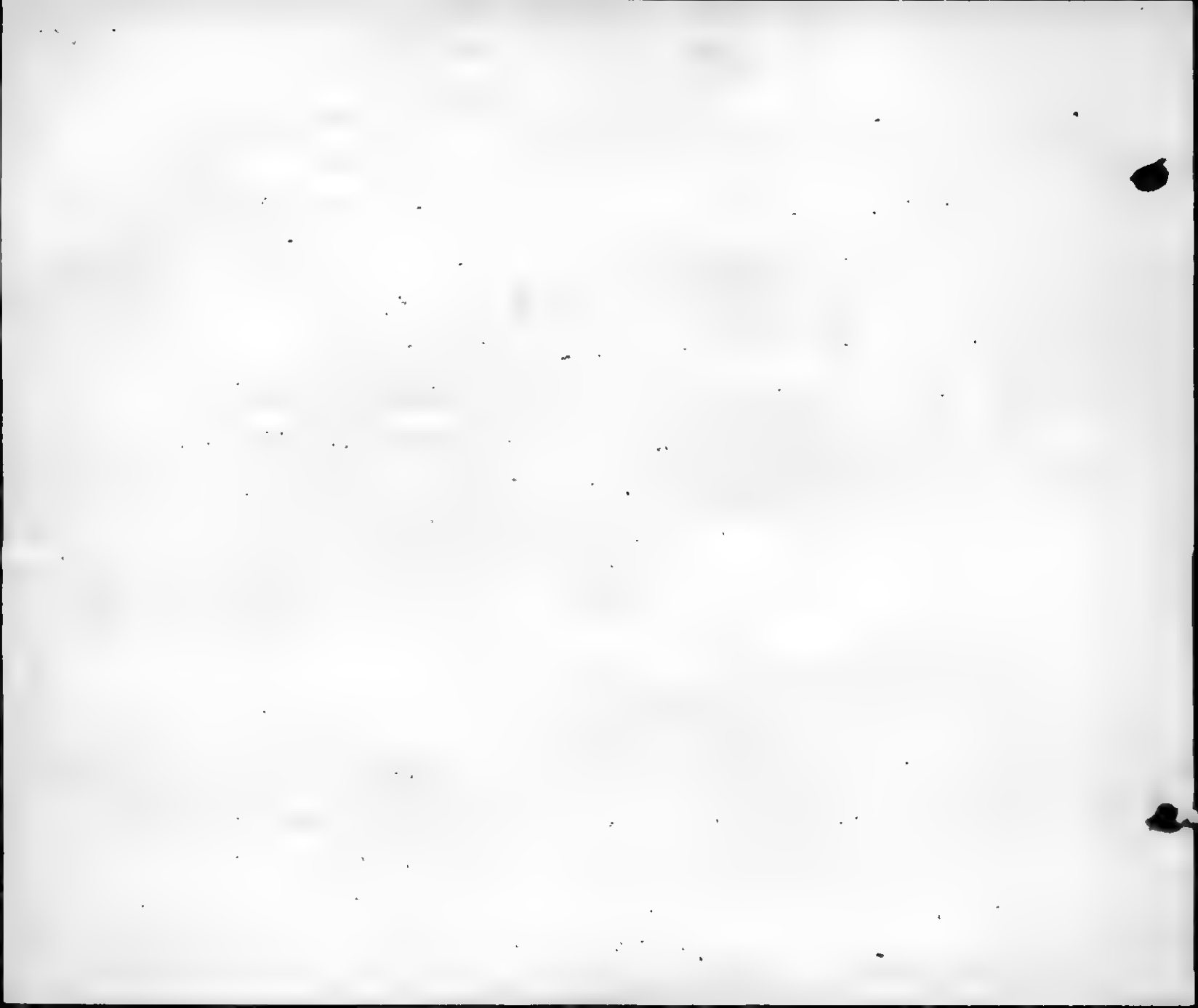
1728 CERTIFICATE OF DEATH

Reg. Dist. No.

01719

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2800 CUB HILL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CUB HILL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2800 CUB HILL ROAD</u>		d. STREET ADDRESS <u>967 D L MARSH ROAD #34</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ERNSTENA K RYE</u>		4. DATE OF DEATH Month Day Year <u>FEB 20 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 3, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHRISTIAN C RYE</u>		14. MOTHER'S MAIDEN NAME <u>JOHANNA DUMHARDT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>L. EDWARD RYE</u>		Address <u>2800 CUB HILL ROAD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>congestive failure</u> (c) <u>genl arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5-10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>—</u>
21. I certify that I attended the deceased from <u>Mar 1, 1950</u> to <u>2/20, 1960</u> that I last saw the deceased alive on <u>2/19, 1960</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>3009 EVERGREEN AVE</u> ACTUAL SIGNATURE <u>Donald W. Mintzer</u> M.D. PHYSICIAN'S NAME (Type) <u>DONALD W. MINTZER</u> <u>BALTIMORE MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/20/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James P. ...</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.  
**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**1729 CERTIFICATE OF DEATH**

01720

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the pines</b>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>SAGER</b> Last				4. DATE OF DEATH Month <b>Feb.</b> Day <b>14</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) <b>90</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Merchant</b>		11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Rose Lazarus 3706 Liberty Heights Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Decomposition</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ch. Arteriosclerosis + Cerebral arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b> <b>103rd(?)</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-26-1960</b> to <b>2-14-1960</b> , that (I) <del>was</del> lost saw the deceased alive on <b>2-14-1960</b> , and that death occurred <b>04:30 PM</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>William K. Gallagher</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>2/15/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>William K. Gallagher M.D.</b>				22d. ADDRESS <b>6209 Friedrich Ave. Balt. 28, Md.</b>			
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/16/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Both Tfiloh</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William K. Gallagher</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 17 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hearn</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

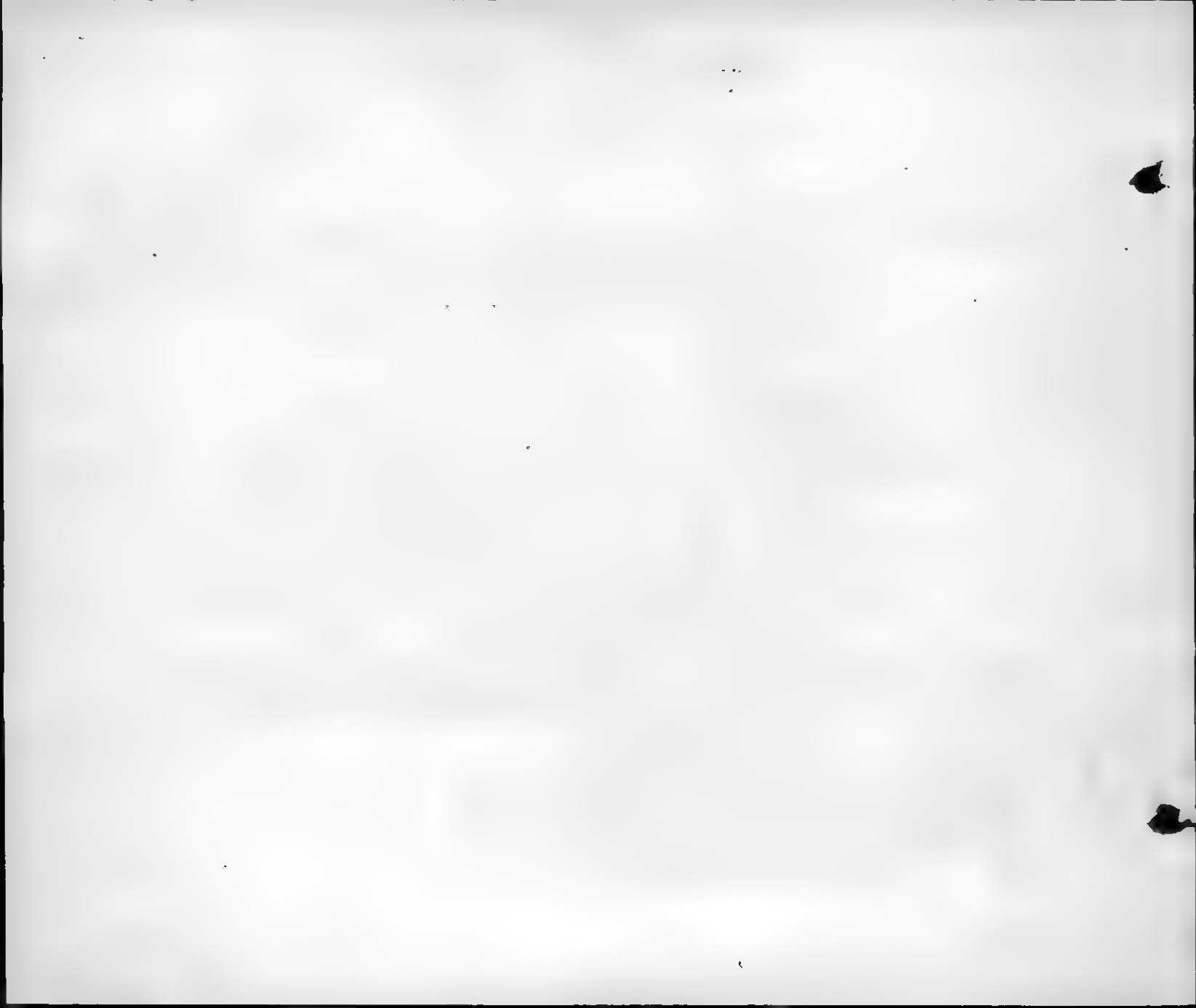
VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01721

1730 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1415 Linden Avenue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Presbyterian Home</u>		d. STREET ADDRESS <u>Baltimore</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clara May Sanders</u>		4. DATE OF DEATH Month Day Year <u>February 12 19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1873</u>
9. AGE (in years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas Edward Sanders</u>		14. MOTHER'S MAIDEN NAME <u>Mary Susan Aueos</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>T.E. Elliott Presbyterian Home</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c) <u>Coronary heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>12 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above			
22a. SIGNATURE <u>Donald L. Somerville</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Donald L. Somerville</u>		22d. ADDRESS <u>25 W. Pennsylvania Ave., Towson</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-15-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ethel Church</u>		23d. LOCATION (City, town, or county) (State) <u>Madonna, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell &amp; Sons, Inc.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 15 '60</u>	
ADDRESS <u>1900 Eutaw Place</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	





1731

# CERTIFICATE OF DEATH

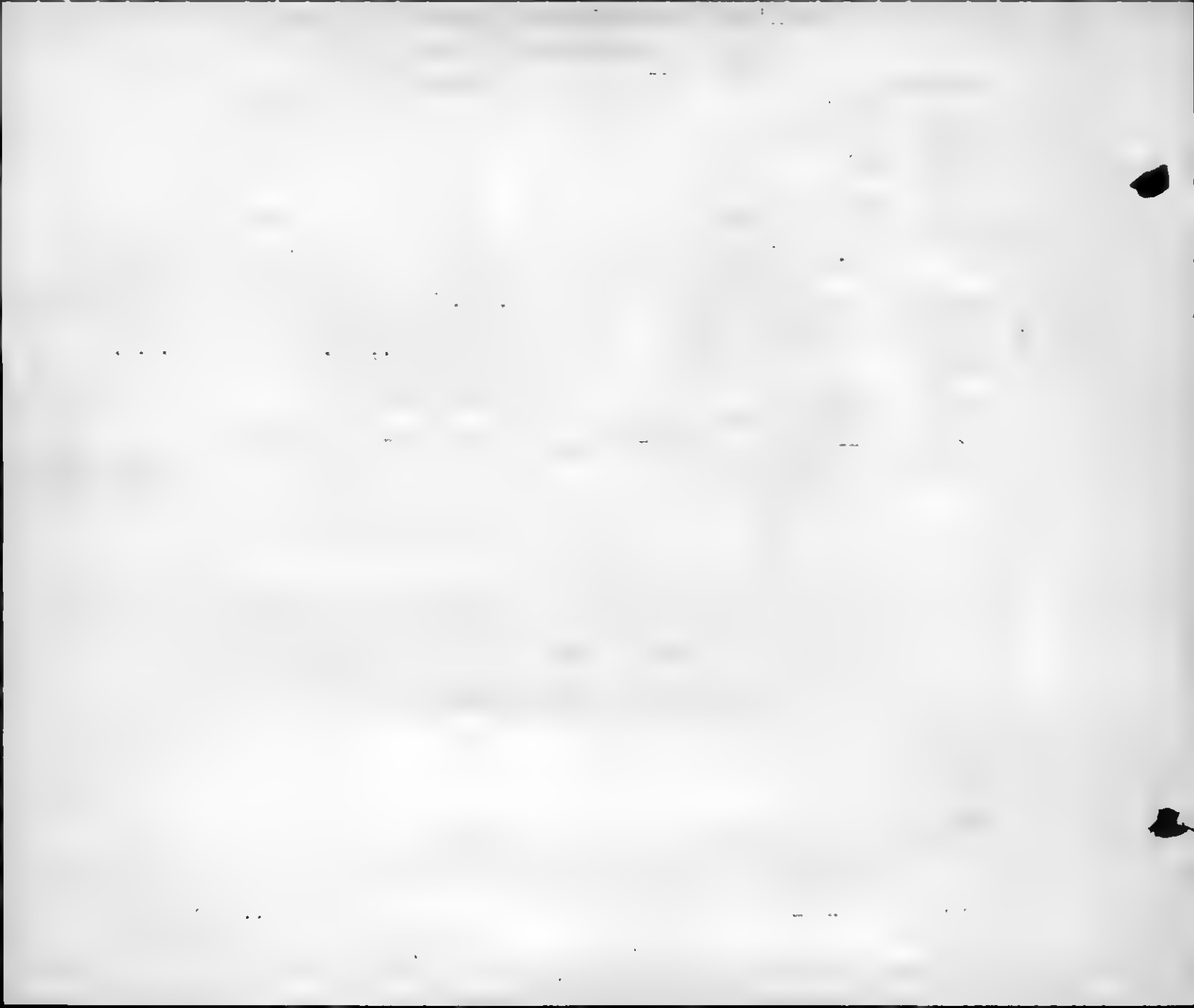
Reg. Dist. No.

01722

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8728 Church Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>H. Wilhelm</b> Middle <b>Sands</b> Last <b>Sands</b>		4. DATE OF DEATH Month <b>February</b> Day <b>23</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 10, 1900</b>
9. AGE (In years last birthday) <b>59</b> yrs		10. IF UNDER 1 YEAR: Months <b>59</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		12. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
13. BIRTHPLACE (State or foreign country) <b>Howard Co., Md.</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>James Sands</b>		16. MOTHER'S MAIDEN NAME <b>Mary Nelson</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		18. SOCIAL SECURITY NO. <b>213-18-8765</b>	
19. INFORMANT <b>Dorothy Sands - 8728 Church Lane</b>		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocarditis</b> (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Jan. 29, 1960</b> to <b>Feb. 23, 1960</b> , that I last saw the deceased alive on <b>Feb. 22, 1960</b> , and that death occurred at <b>8:45 P. M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>W. E. Martin</b> M.D. <b>Randallstown Md</b> PHYSICIAN'S NAME (Type) <b>William E. Martin Randallstown Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-27-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>West Liberty</b>		22d. LOCATION (City, town, or county) (State) <b>Howard Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Lane</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 26 '60</b>	
ADDRESS <b>802 Madison Avenue Baltimore, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1732

01723

1

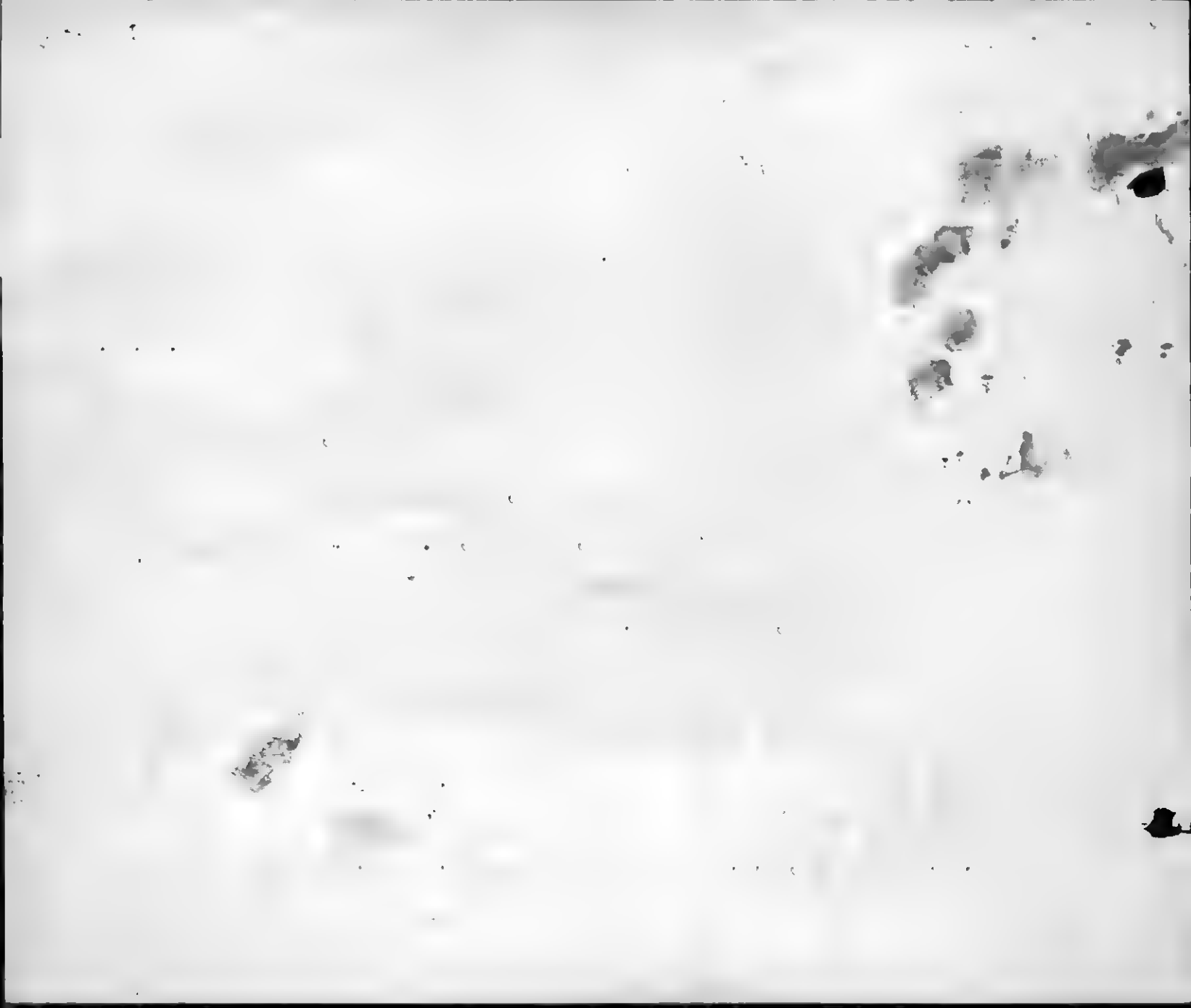
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>6 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>R.</b> Last <b>SAYLOR</b>				4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 23, 1883</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>Henry C. Saylor</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Robinson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (List no. or unit) <b>Yes WW I</b>				16. SOCIAL SECURITY NO. <b>577-14-3320</b>		17. INFORMANT Address <b>Division Clinical Records, VAH, Balto. 18, Md. Ft. Howard /</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS, BASILAR ARTERY</b> DUE TO <b>CEREBRAL ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>PEPTIC ULCERS, MULTIPLE, DUODENUM WITH MASSIVE HEMORRHAGE</b> (c) <b>ACUTE PURULENT BRONCHITIS</b>							INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>OLD</b> <b>RECENT &amp; OLD</b> <b>RECENT</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROSIS, GENERALIZED. BENIGN PROSTATIC HYPERTROPHY</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>Feb. 12</b> , 19 <b>60</b> , to <b>Feb. 18</b> , 19 <b>60</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>Feb. 18</b> , 19 <b>60</b> , and that death occurred at <b>5:30 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>W. J. Pijanowski</b>				22b. DATE SIGNED <b>2/18/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>W. J. PIJANOWSKI, M.D.</b>				22d. ADDRESS <b>BALTO. 18, MD. FORT HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-20-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc.</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 25 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kimes</b>	

6009 Harford Rd.

Baltimore 14, Maryland



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1733

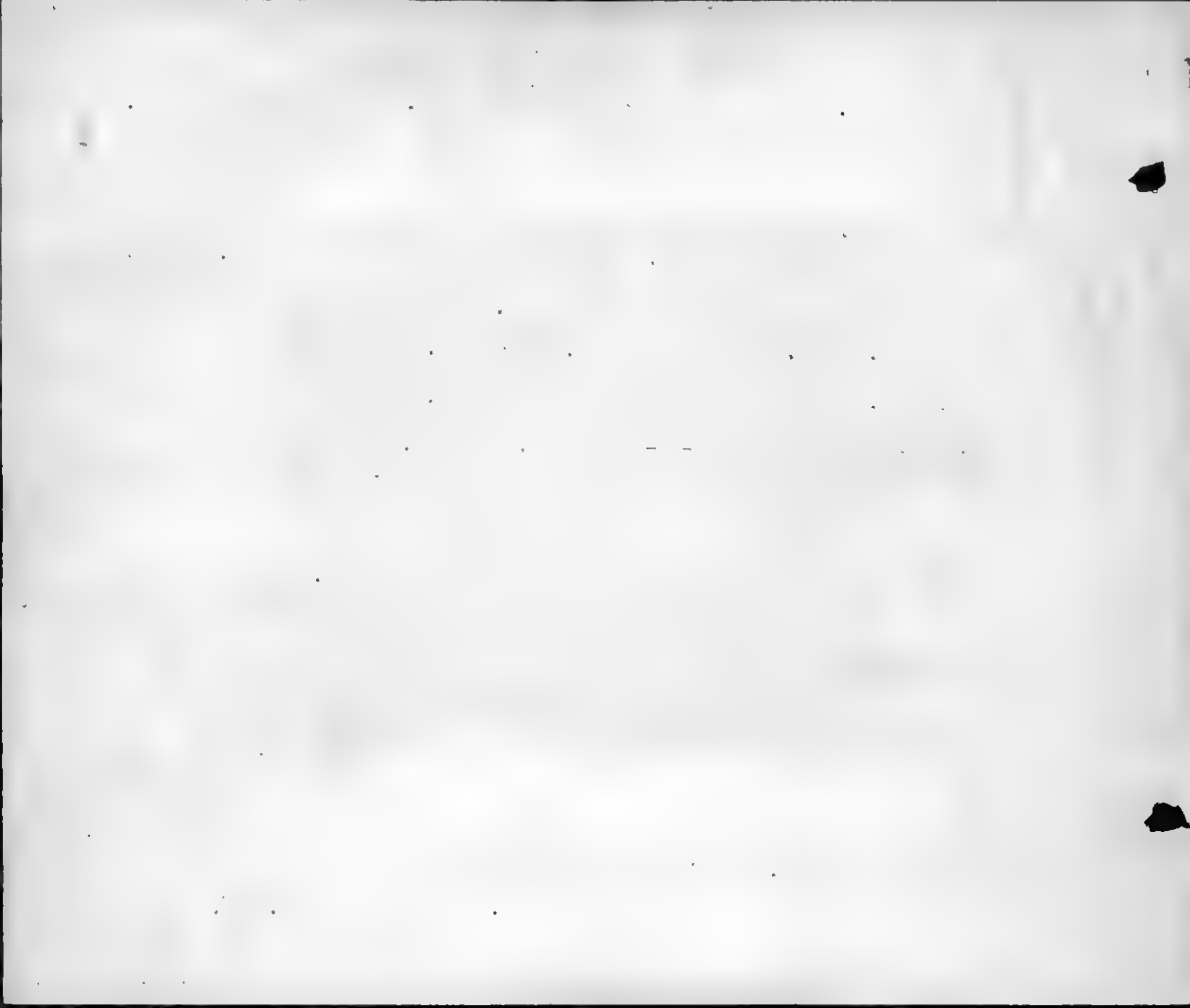
## CERTIFICATE OF DEATH

Reg. Dist. No.

01724

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Anneslie</b> c. LENGTH OF STAY IN 1b <b>Anneslie X</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>508 Castle Drive</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Anneslie X</b> d. STREET ADDRESS <b>508 Castle Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>E.</b> Last <b>SCHAEFER</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>23</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 28, 1898</b> 9. AGE (In years last birthday) <b>61</b> yrs IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst Sec. Treas. Credit Union Dept. Store</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>Md.</b>	
13. FATHER'S NAME <b>Joseph P. McKenna</b>		14. MOTHER'S MAIDEN NAME <b>Anna E. Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>216-03-4532</b> 17. INFORMANT <b>Mr. Edward A. Schaefer - 508 Castle Drive</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1 hr</b> <b>Days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>Days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <b>19</b> Day <b>17</b> Hour <b>12</b> o. m. <b>12</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Baltimore</b> (County) <b>Balto.</b> (State) <b>Md.</b>
21. I certify that I attended the deceased from <b>July 1959</b> to <b>Feb 23, 1960</b> , that I last saw the deceased alive on <b>Feb 17, 1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3601 Greenway Baltimore 2784-60</b> DATE SIGNED <b>2784-60</b>			
ACTUAL SIGNATURE <b>Stephen J. Van Lill</b>		PHYSICIAN'S NAME (Type) <b>Stephen J. Van Lill</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/25/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Tiekner &amp; Sons - Balto 17</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 25 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1734

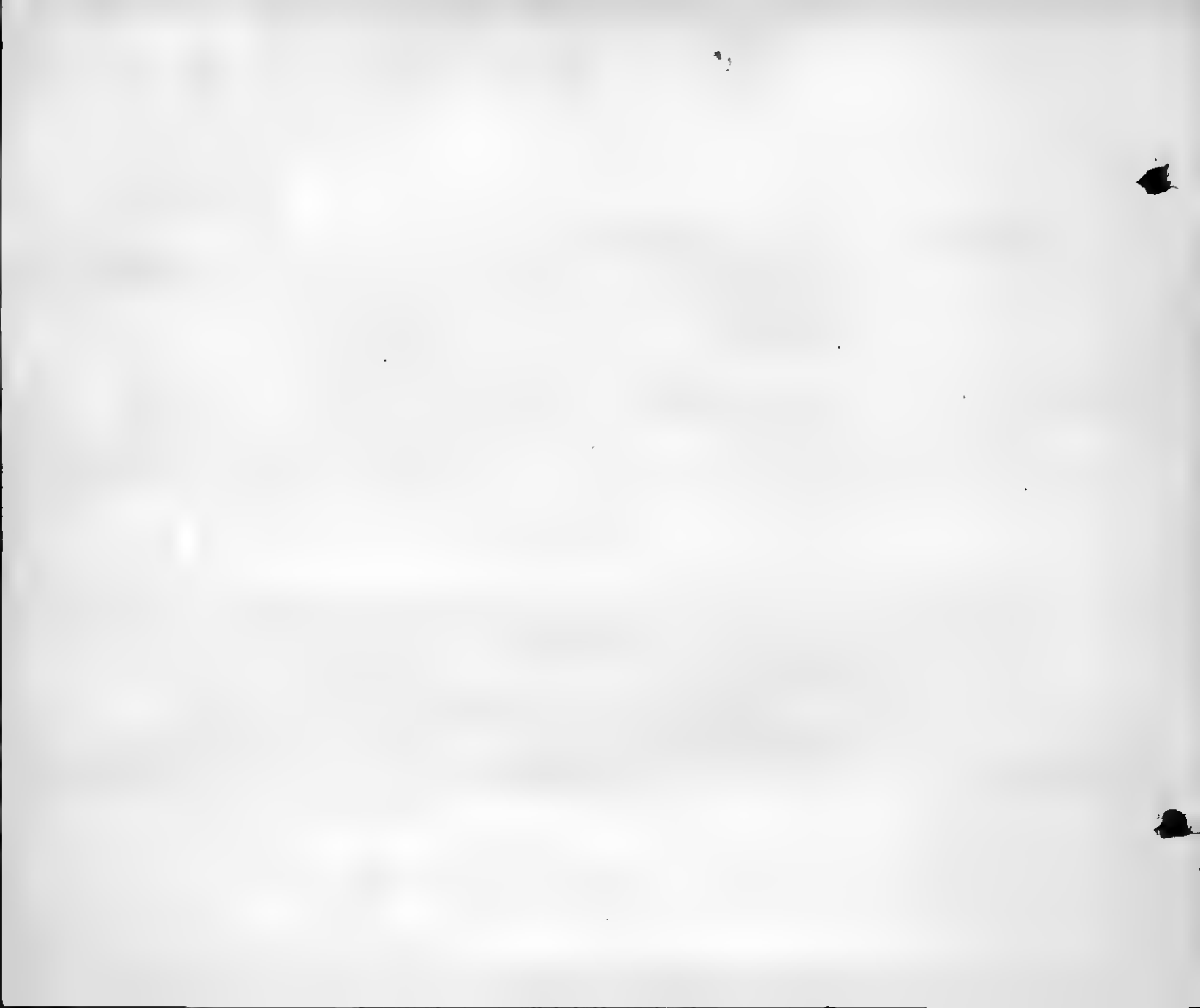
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balto</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Overlea</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>19 Walnut Ave</u>		d. STREET ADDRESS <u>19 Walnut Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Christopher Schmidt</u>		4. DATE OF DEATH Month Day Year <u>Feb 5 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 2 1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Statistician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. &amp; O.</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>August Schmidt</u>		14. MOTHER'S MAIDEN NAME <u>Anna ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-05263</u>	
17. INFORMANT <u>Hamilton A. Schmidt</u>		Address <u>19 Walnut Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>480X Broncho-pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gr ppe</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>12 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1946</u> to <u>Feb 5</u> , 1960, that I last saw the deceased alive on <u>Feb 5</u> , 1960, and that death occurred at <u>7 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R Donald Jandorf</u> M.D.		ADDRESS (Street, city or town, state) <u>6057 Hayford Rd</u>	
PHYSICIAN'S NAME (Type) <u>R Donald Jandorf</u>		DATE SIGNED <u>2-5-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-8-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Eastern Ave Rd Balto. Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dippel Bros.</u>		ADDRESS <u>7110 Belair Rd</u>	
24a. REC'D BY REGISTRAR <u>FEB 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 2 of death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





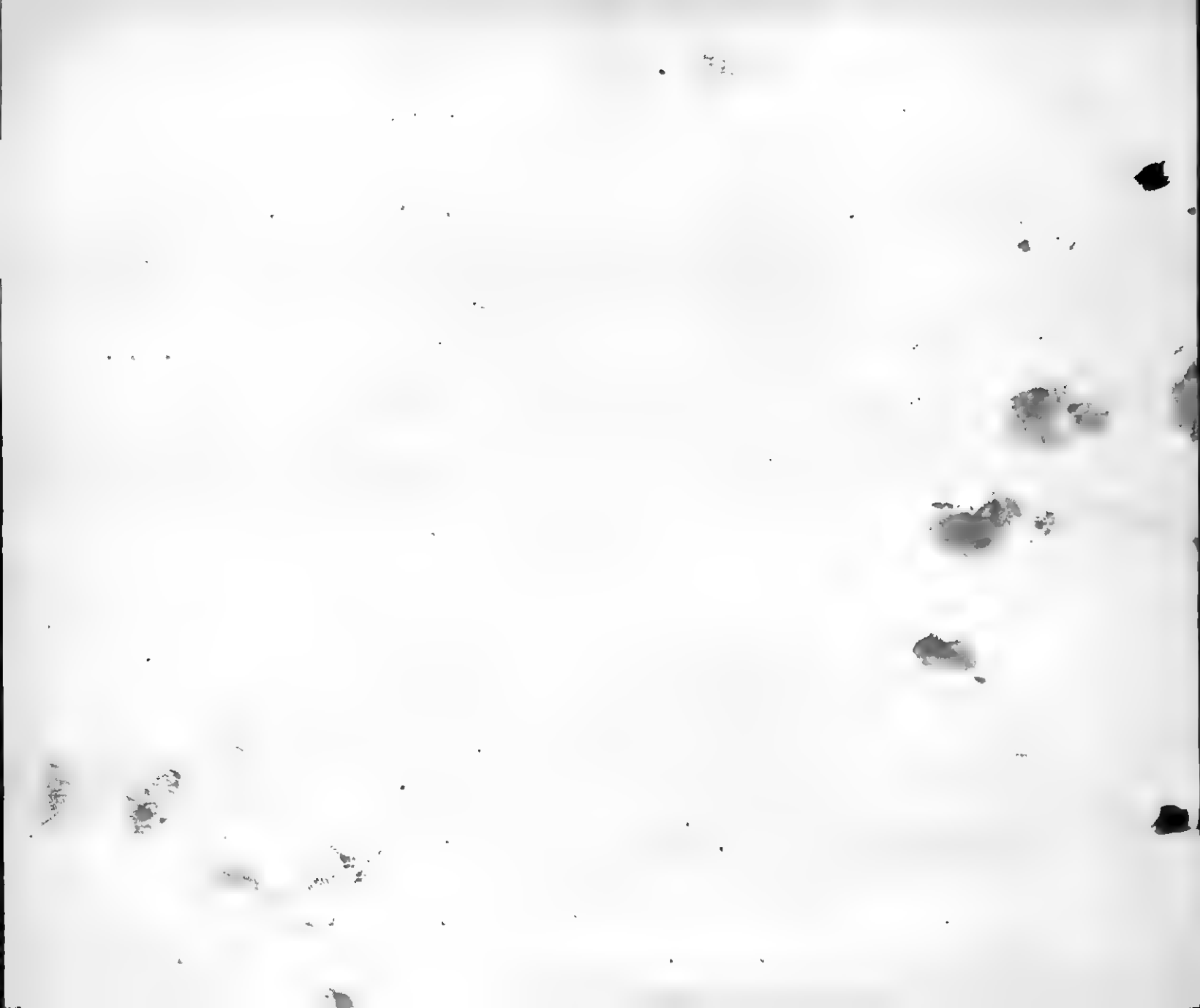
1735

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN lb <b>6yr 4 days</b>		d. STREET ADDRESS <b>1400 W. Lexington St.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Albert</b> Last <b>Schmidt</b>		4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-19-36</b>
9. AGE (In years last birthday) <b>22</b> yrs		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>10</b> Hours <b>15</b> Min.	11. IF UNDER 24 HRS. Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Bertha Mann</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>UNKNOWN</b>	
16. SOCIAL SECURITY NO <b>218-10-2493A</b>		INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio Vasc. Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, general, Hves</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11/24</b> , 19 <b>59</b> , to <b>2/20</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>2/20</b> , 19 <b>60</b> , and that death occurred at <b>2:15a</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		DATE SIGNED <b>2/20/60</b>	
PHYSICIAN'S NAME (Type) <b>STELLA WACHSLER</b>		<b>Catonsville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2-23-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 25 '60.</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 1736 CERTIFICATE OF DEATH

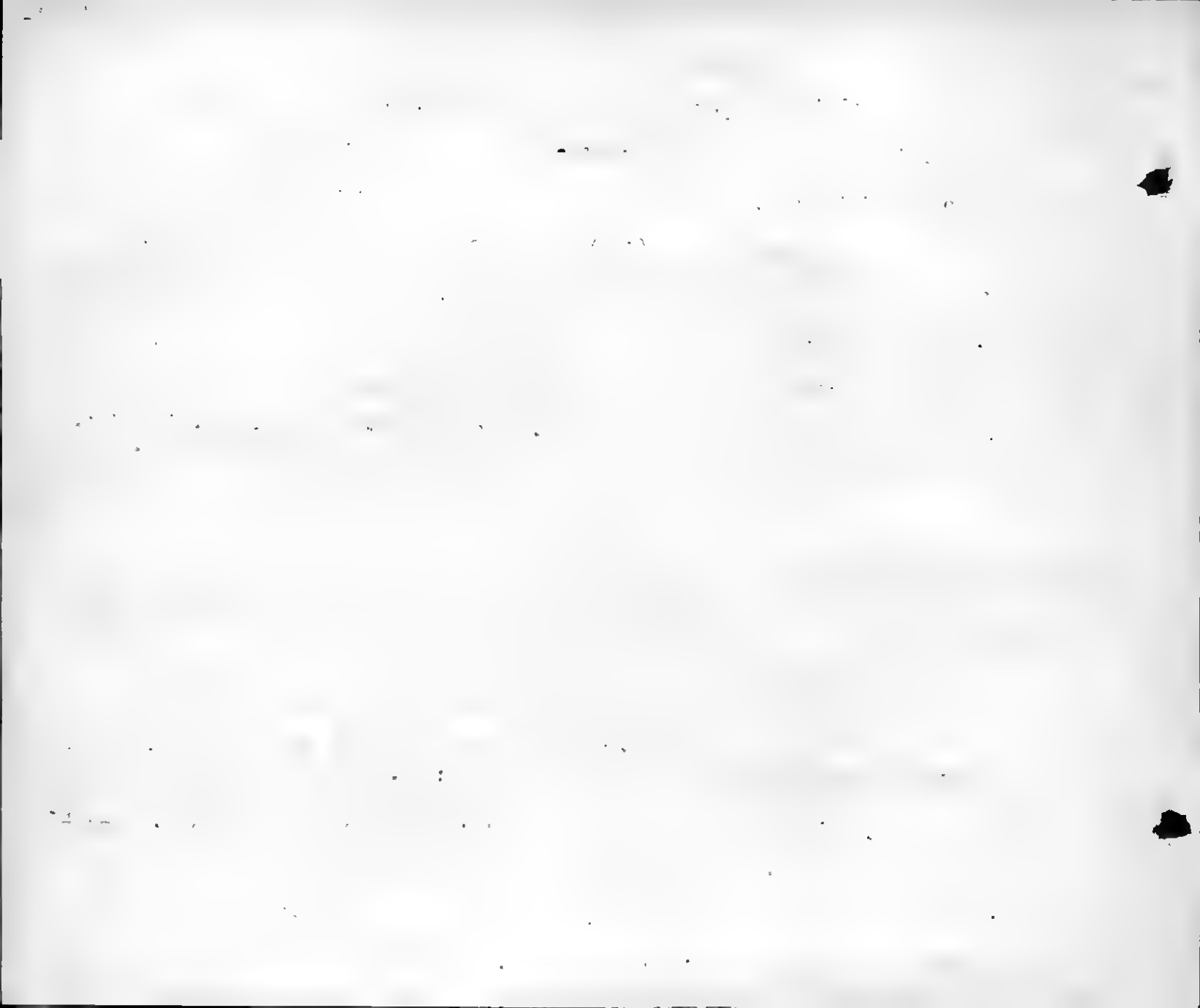
Reg. Dist. No.

96

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>32yrs10mos7days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. STREET ADDRESS <b>5405 Summerfield Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>AUGUST</b> Middle <b>(NMI)</b> Last <b>SCHMITZ</b>		4. DATE OF DEATH Month <b>February</b> Day <b>28</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 1, 1890</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>AUGUST SCHMITZ</b>		14. MOTHER'S MAIDEN NAME <b>LAURA HAUMANN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW-I</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia bilateral unresolved</b> 4-1X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis generalized moderate</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7-10 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 21, 1927</b> to <b>February 28, 1960</b> , and that death occurred at <b>2:50 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>2-29-60</b>			
ACTUAL SIGNATURE <b>J. L. Garey</b> M.D.		PHYSICIAN'S NAME (Type) <b>J. L. GAREY Clinical Pathologist</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>3/1/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Unknown</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bennington &amp; Son</b>		ADDRESS <b>Havre de Grace, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAR 2 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1737 CERTIFICATE OF DEATH

01728

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>16 DUTTON AVE.</b>		d. STREET ADDRESS <b>16 DUTTON AVE.</b>	
3. NAME OF DECEASED (Type or print) First <b>MICHAEL</b> Middle <b>SCHOTT</b> Last		4. DATE OF DEATH Month <b>FEB.</b> Day <b>8</b> Year <b>1960</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 2, 1878</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN-RET.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MEAT CO.</b>	
11. BIRTHPLACE (State or foreign country) <b>OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN SCHOTT</b>		14. MOTHER'S MAIDEN NAME <b>JOHANNA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Hubert Krebs - 16 Dutton Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>① Degenerative Heart Disease</b> <b>422.2</b> DUE TO (b) <b>② Bronchiectasis chronic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <b>③ Bronchitis Acute &amp; chronic</b> <b>④ Emphysema Pulmonary chronic</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>⑤ Cholangitis chronic</b>			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>56</b> to <b>2/8/60</b> , that I last saw the deceased alive on <b>2/6/60</b> and that death occurred at <b>600A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. E. Mc Grath</b> M.D.		ADDRESS (Street, city or town, state) <b>1303 Frederick Rd Catonsville 28md</b>	
PHYSICIAN'S NAME (Type) <b>W. E. Mc Grath</b>		DATE SIGNED <b>2/8/60</b>	
22a. BURIAL, CREMATON, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>2-8-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Brookside Catholic Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Brookside, Anne.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Farley Funeral Home, Catonsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 9 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Howard</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

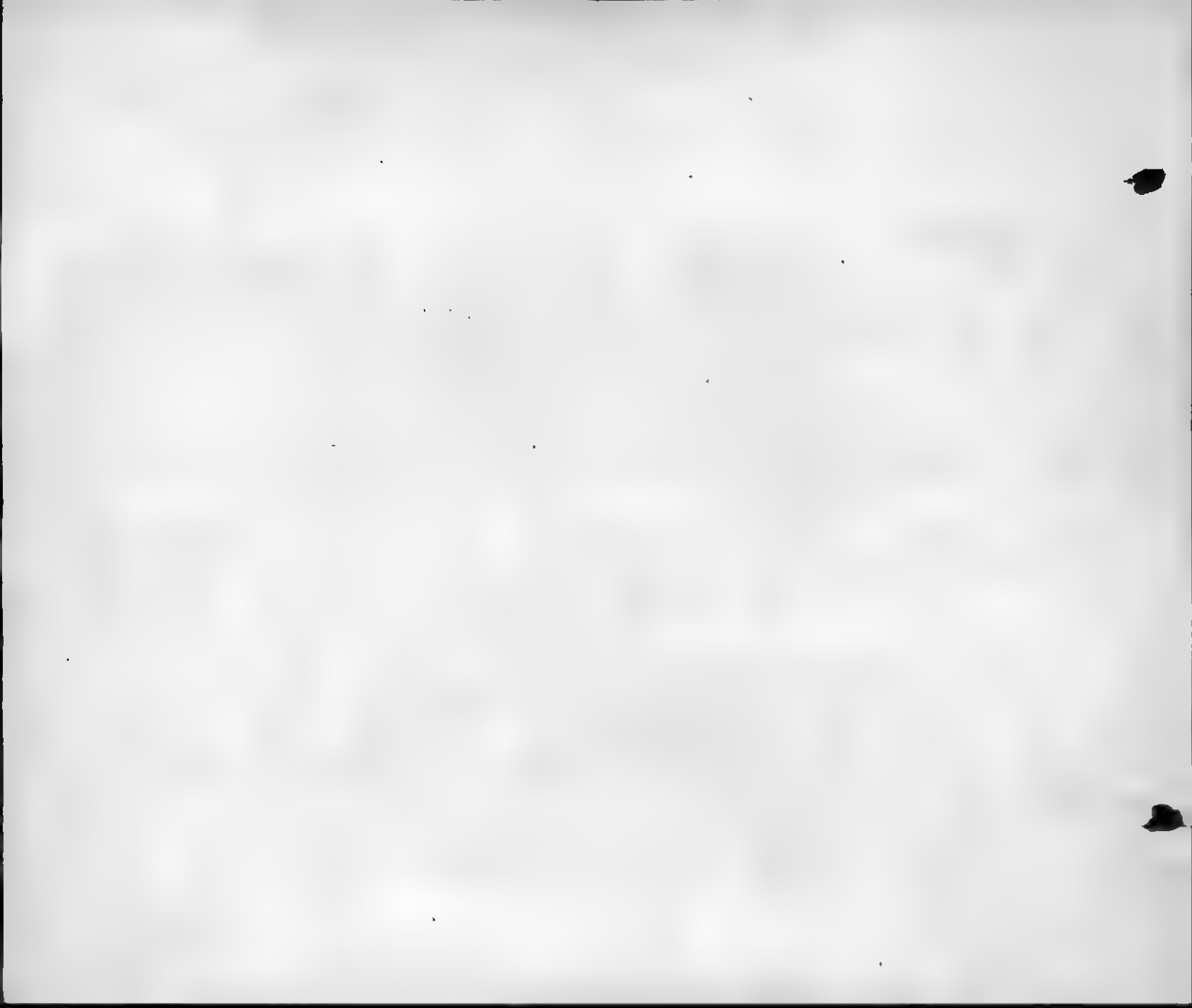
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01723

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1435 Taylor Avenue</u>		d. STREET ADDRESS <u>1435 Taylor Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Mr. Warner</u> First <u>Schudell</u> Middle Last		4. DATE OF DEATH <u>February 25th</u> 19 <u>60</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 17, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Sweden</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>		16. SOCIAL SECURITY NO. <u>214-05-0822</u>	
17. INFORMANT <u>Mr. Warren Schudell</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO <u>?</u> (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>?</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/29/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 1 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur A. Ruck</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

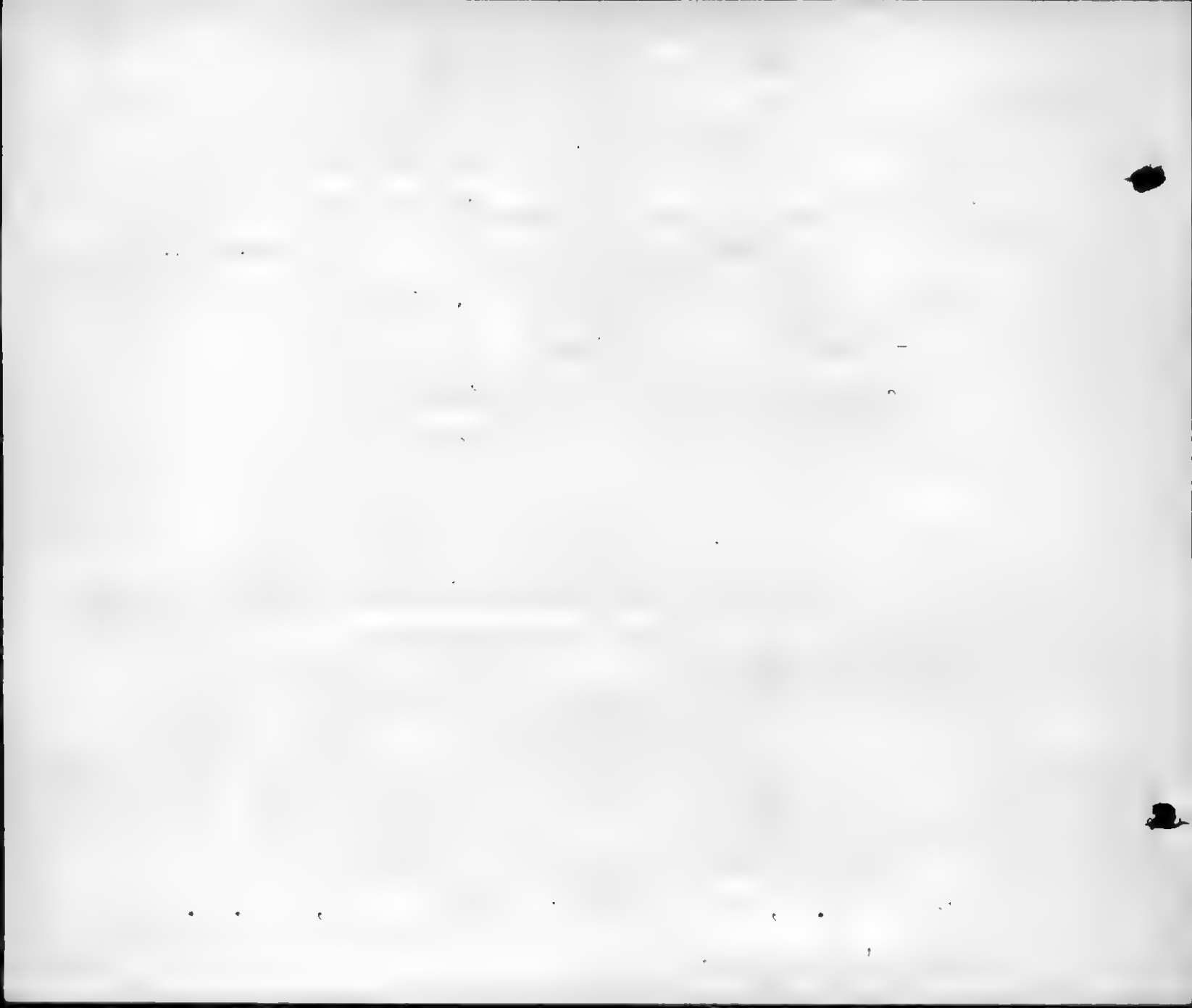
STATE OF MARYLAND  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1739

CERTIFICATE OF DEATH

01750

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Arm</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Arm</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Long Green Pike</b>		d. STREET ADDRESS <b>Long Green Pike</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>HARRY SCHWEIKART</b>		4. DATE OF DEATH Month <b>February</b> Day <b>14</b> , Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1885</b>
9. AGE (In years last birthday) <b>74</b> yrs	IF UNDER 1 YEAR Months <b>74</b> Days <b>19</b> Hours <b>19</b> Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer-retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Martin Shhweikart</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Family Records</b>
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cornary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiac Insufficiency</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>4 yrs</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1958</b> to <b>Feb-14</b> , 1960, that (I) (we) last saw the deceased alive on <b>Feb-13</b> , 1960, and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter M. Hammatt</b> M.D.		22b. DATE SIGNED <b>Feb-16-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Walter M. Hammatt</b>		22d. ADDRESS <b>Baldwin</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 17, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fork Methodist Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Fork, Balto. Co., Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>		25a. RECEIVED BY REGISTRAR <b>Feb 16 1960</b>	
		25b. REGISTRAR'S SIGNATURE <b>Carroll D. Pender</b>	

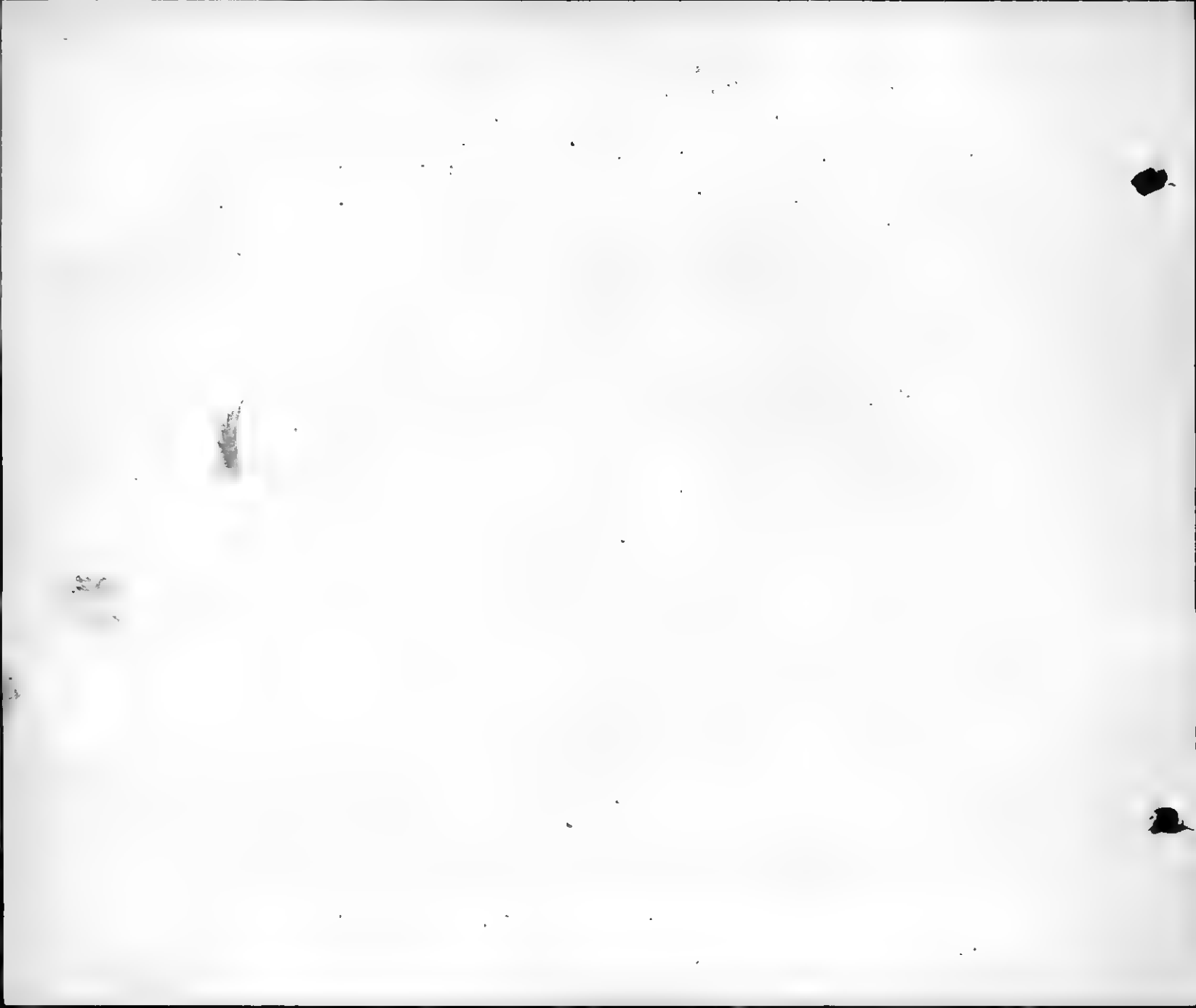


01731

## 1740 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eastonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10711 HATFIELD - Bowie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Home State Ho-p.</u>		d. STREET ADDRESS <u>903 Maple Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Ann</u> Middle <u>W.</u> Last <u>Shen</u>		4. DATE OF DEATH Month <u>February</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-25-11</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Morgan</u>		14. MOTHER'S MAIDEN NAME <u>Gabriella Wood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Informant</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>Generalized Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Febr. 11</u> , 19 <u>60</u> , to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>4:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward T. Schnoor</u> M.D.		DATE SIGNED <u>Feb 18 1960</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD T. SCHNOOR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/14/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Perkins Chapel Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bowie Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Death Care</u>		24a. REC'D BY REGISTRAR <u>Feb 16 60</u>	
ADDRESS <u>3118 Prince Georges Rd</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. ...</u>	



1741

HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

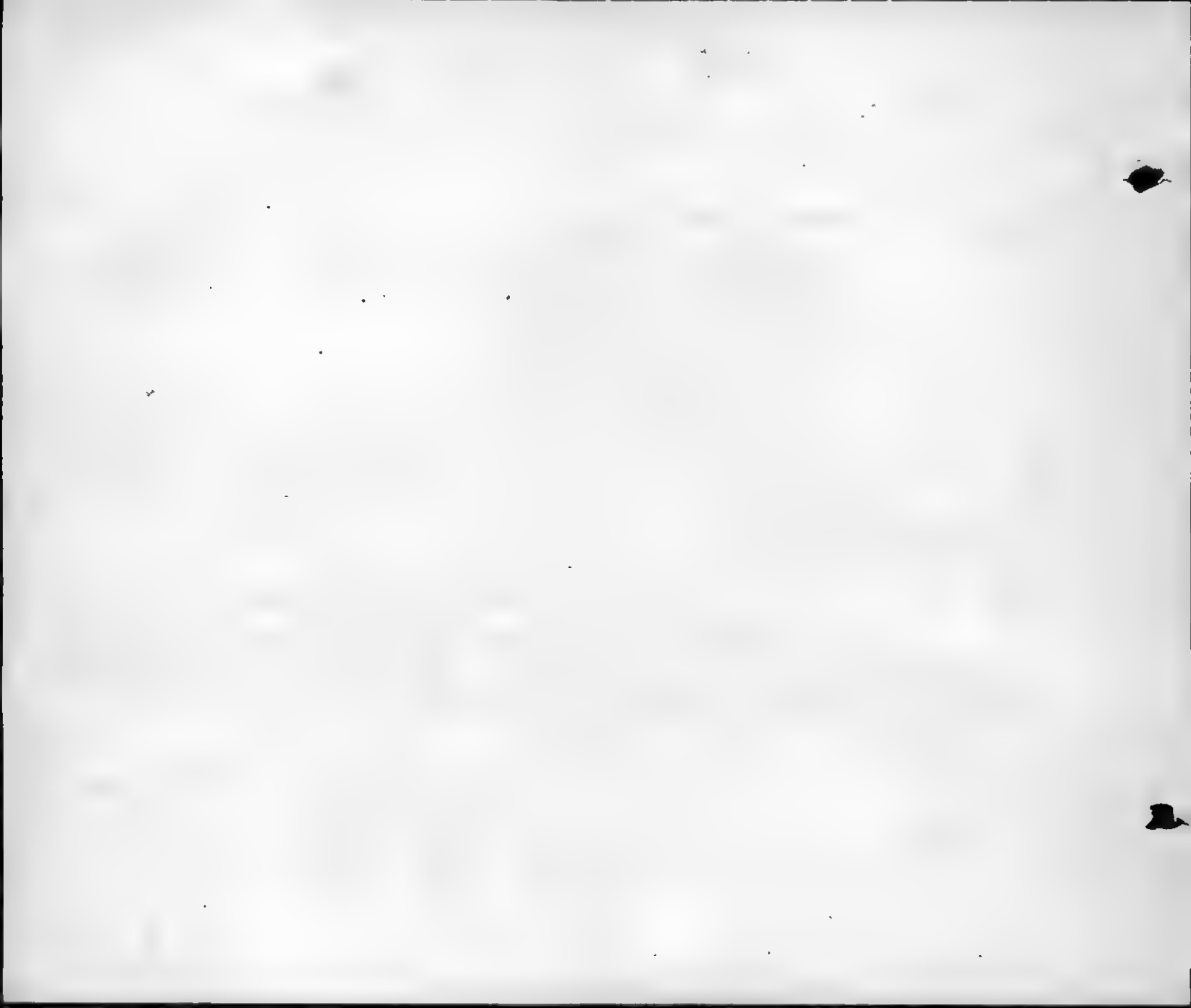
1741

CERTIFICATE OF DEATH

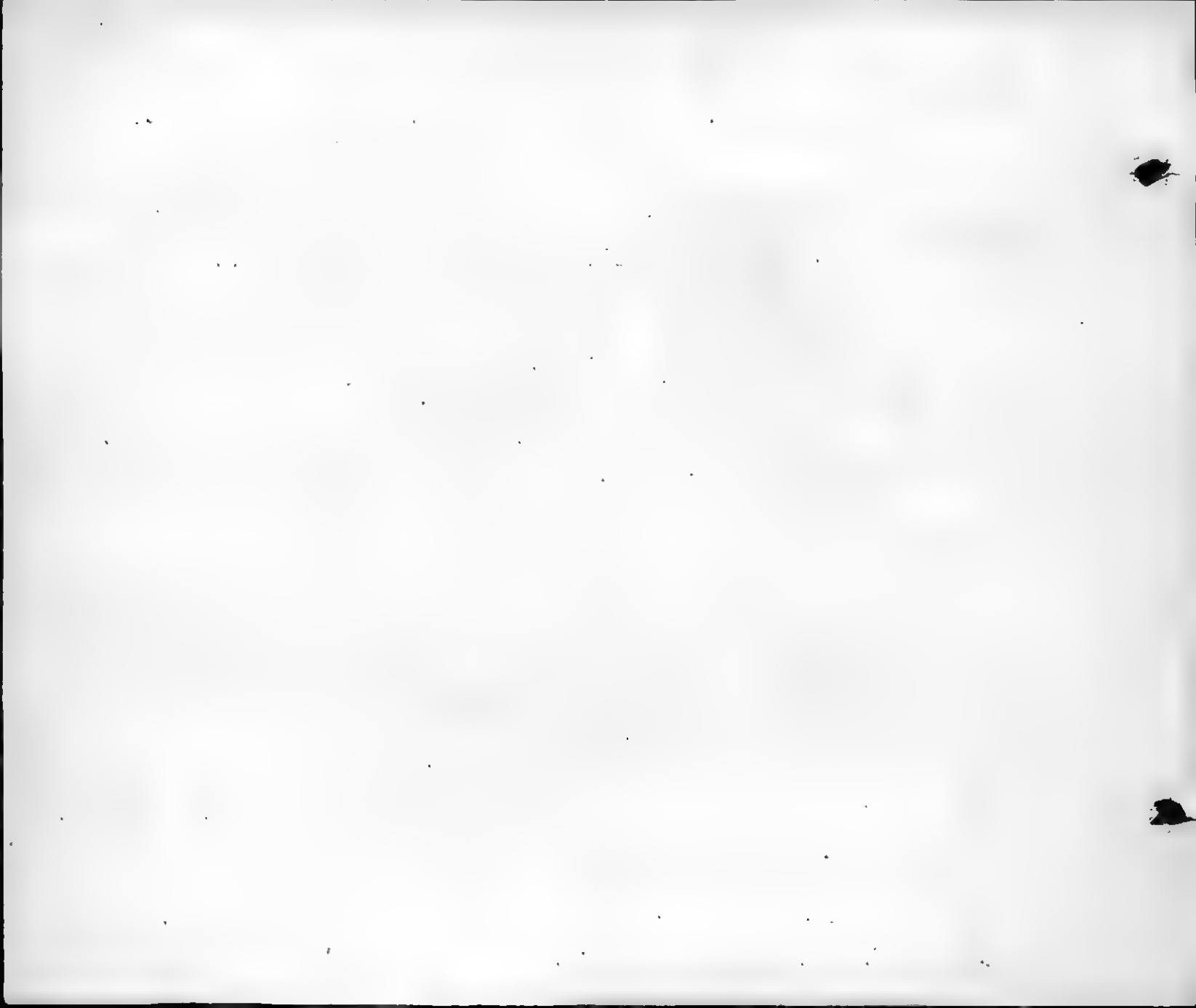
01732

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Y</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>	c. LENGTH OF STAY IN lb <b>7 YEARS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> <b>2V 14</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		d. STREET ADDRESS <b>708 WEST 34TH ST</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JENNIE</b> Middle <b>E</b> Last <b>SHEFFER</b>		4. DATE OF DEATH Month <b>FEB</b> Day <b>28</b> Year <b>1960</b>	
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-6-1884</b>
9. AGE (In years, lost birthday) <b>75 yrs</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>5</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>JOSEPH LITCHFIELD</b>	
14. MOTHER'S MAIDEN NAME <b>MARGARET SAKERS</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Frank L. Smith Jr., Cockeysville, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anterior Myocardial Infarction</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Vascular Disease</b> (c) <b>Diabetes</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1-23</b> , 19 <b>57</b> , to <b>2-26</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>2-26</b> , 19 <b>60</b> , and that death occurred at <b>7:00 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter T. Kees</b>		22b. DATE SIGNED <b>2/28/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>		22d. ADDRESS <b>COCKEYSVILLE MD</b>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>March 3, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wood Ridge</b>	23d. LOCATION (City, town, or county) (State) <b>Cockeysville, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Burke Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Mar 1 '60</b>	
ADDRESS <b>347 Falls Road</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MEDICAL CERTIFICATION









# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1743 CERTIFICATE OF DEATH

01734

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - ROCKDALE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RURAL - ROCKDALE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LIBERTY RD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>CLIFTON</u> Last <u>SLEMAKER</u>				4. DATE OF DEATH Month <u>2</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/11/1917</u>	9. AGE (In years last birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ACCOUNTANT</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>JOHN H. SLEMAKER</u>				14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT <u>WIFE -</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF STOMACH</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>INANITION</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>8 MONTHS</u> <u>5 MONTHS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>NOV. 1956</u> , to <u>FEB 21, 1960</u> , that I last saw the deceased alive on <u>FEB 13, 1960</u> , and that death occurred at <u>11:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edwin L. Pieppont</u> M.D. <u>8224 LIBERTY RD.</u>				DATE SIGNED <u>2/21/60</u>			
PRINTED NAME (Type) <u>EDWIN L. PIEPPONT</u>				<u>BALTO 7, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-24-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) <u>Balto., md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u> ADDRESS <u>4600 liberty Hghts. Ave.</u>				24a. REC'D BY REGISTRAR <u>FEB 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 174 CERTIFICATE OF DEATH

Reg. Dist. No. 32

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore County</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Mt. Wilson, Maryland</u>		<u>6 months</u>		TOWN <u>Silver Springs</u>		/	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Mt. Wilson State Hospital</u>				<u>1014 Woodside Park,</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>XXXXXX, Mr. Curtis L. Sowers</u>				<u>Feb. 5 1960</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<u>male</u>	<u>white</u>	<u>married</u>	<u>Feb. 14, 1896</u>	<u>63</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>attorney</u>		<u>Dept. of Defense</u>		<u>Woodstock, Pennsylvania</u>		<u>U S A</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>XXXXXX Bell Benjamin Sowers</u>				<u>XXXXXX Minnie Koutz</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>no</u>		<u>none</u>		<u>Hospital Records</u> <u>Mt. Wilson State Hospital</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>IMMEDIATE CAUSE (A)</b> <u>Pulmonary tuberculosis</u>						<u>8 months</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Pericarditis</u>						<u>1 month</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)</b>		<b>21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>7/22/</u> <u>1959</u>, to <u>2/5/</u> <u>1960</u>, that I last saw the deceased alive on <u>2/5</u> <u>1960</u>, and that death occurred at <u>10:45 A</u> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>			
<u>Wm. Newcomer, M.D. Superintendent, Mt. Wilson, Md.</u>				<b>DATE SIGNED</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>BURIAL</u>		<u>2/8/60</u>		<u>PARKLAWN CEMETERY</u>		<u>MONTGOMERY COUNTY, MARYLAND</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<u>FEB 9 '60</u>		<u>Arthur S. Kraus</u>		<u>WARNER E. PIMPHREY, INC. SILVER SPRING, MD.</u>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

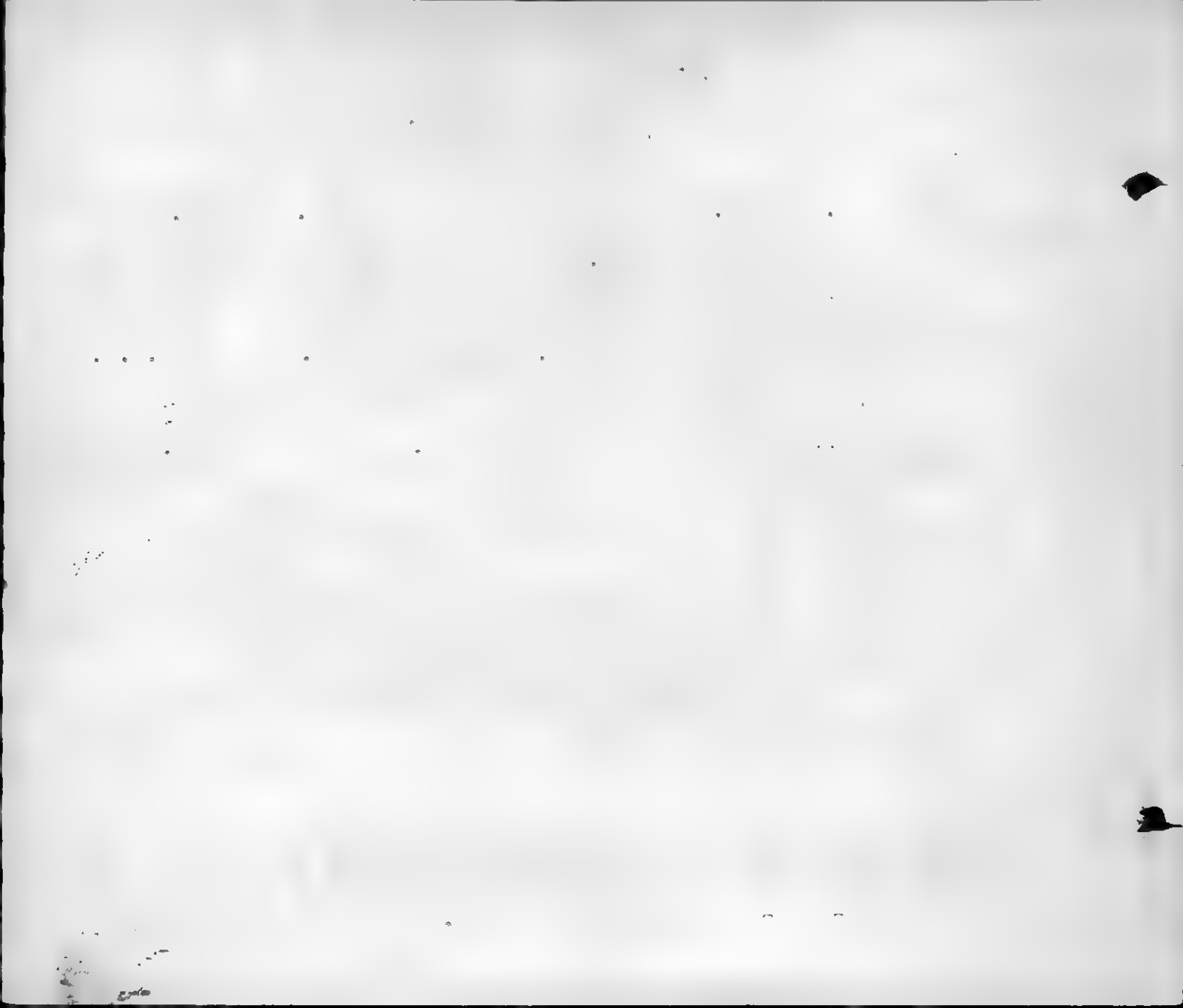
01736

Reg. Dist. No.

1  
FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <span style="float: right;">1745</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middleborough</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>312 Wye Rd. # 21.</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Id.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middleborough</b> d. STREET ADDRESS <b>312 Wye Rd. # 21.</b>	
3. NAME OF DECEASED (Type or print) <b>EUNICE T. SFRIGG</b>		4. DATE OF DEATH Month <b>February</b> Day <b>27</b> Year <b>19 60.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18, 1887</b>
9. AGE (in years last birthday) <b>72 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>? Messick</b>		14. MOTHER'S MAIDEN NAME <b>Sarah ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Dorothy E. Horney</b>		Address <b>Same.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Convalescing fracture of right hip &amp; tibia - 6 weeks</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 Mon</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Jack C. Collins</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Jack C. Collins</b>		DATE SIGNED <b>2-29-60</b>	
22a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-2-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>5608 Dogwood Rd. Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles J. Gailer</b>		ADDRESS <b>901 S. CONNELLING ST. BALTO., 24, MD.</b>	
24a. REC'D BY REGISTRAR <b>MAR 4 '60</b>		24b. REG. STRAR'S SIGNATURE <b>Arthur S. Harn</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

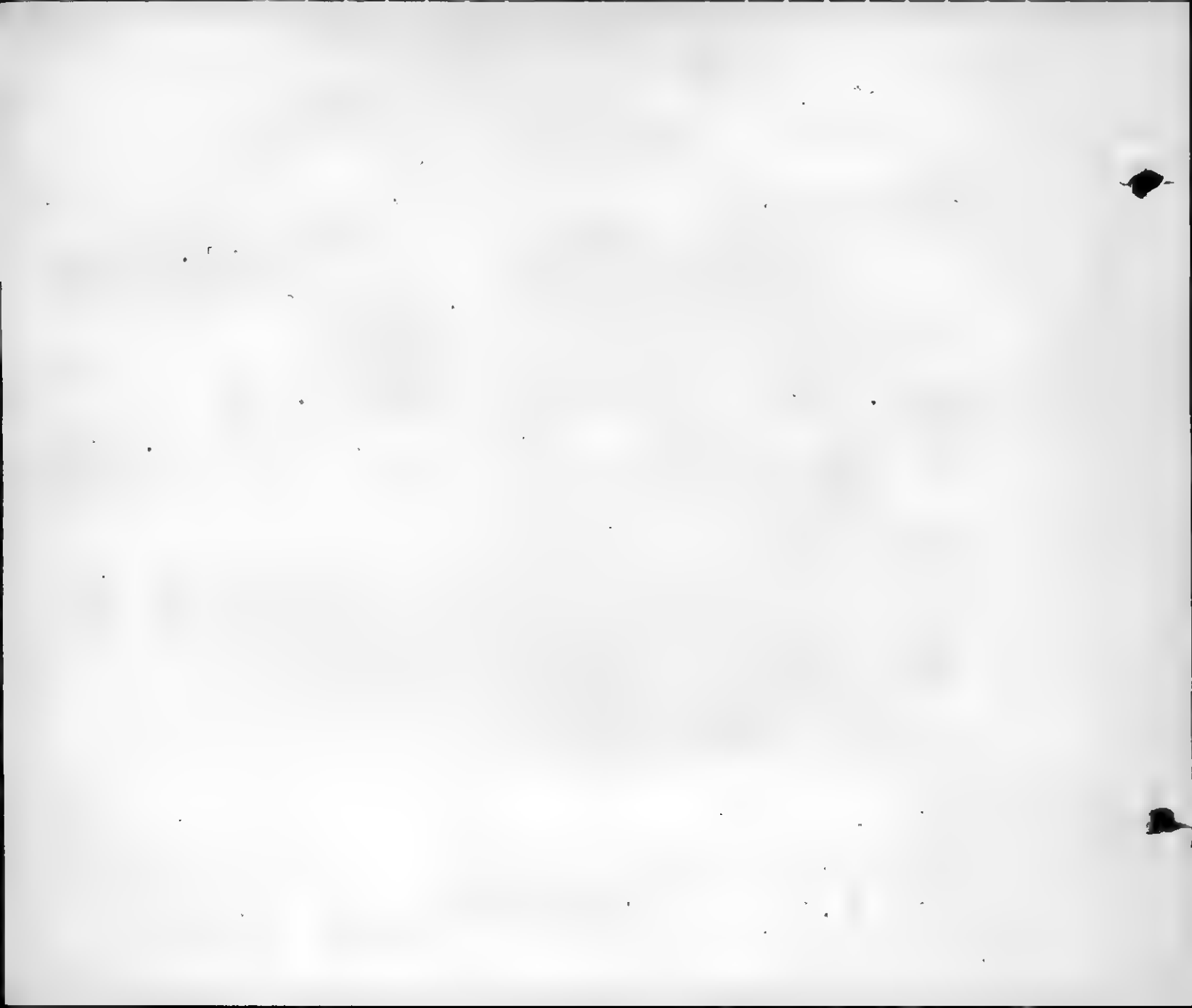
1746

1746

CERTIFICATE OF DEATH

01737

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 4</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8634 Quentin Avenue</b>		/ d. STREET ADDRESS <b>8634 Quentin Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MARGARETTA STAINES</b>		4. DATE OF DEATH <b>February 15, 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 30, 1896</b>
9. AGE (In years last birthday) <b>63</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Malcolm A. Fishpaw</b>		14. MOTHER'S MAIDEN NAME <b>Margaret C. Parks</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Christian Staines, 8634 Quentin Ave., Towson 4</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Duodenal ulcer, obstruction &amp; perforation</b> 541.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Arteriosclerotic Heart Disease Angina pectoris</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1957</b> to <b>Feb 15, 1960</b> , that (I) (we) last saw the deceased alive on <b>2/13</b> 1960 and that death occurred at <b>10:45</b> M. from the causes and on the date stated above.			
21a. SIGNATURE <b>Donald W. Mintzer</b>		21b. DATE <b>Feb 17, 1960</b>	
21c. PHYSICIAN'S NAME (Type) <b>Donald W. Mintzer</b>		21d. ADDRESS <b>3009 EVERGREEN AVE BALTO 14 MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 18, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sater's Baptist Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lutherville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>		23a. RECEIVED BY REGISTRAR <b>FEB 23 60</b>	
23b. REGISTRAR'S SIGNATURE <b>Wm. S. Smith</b>			





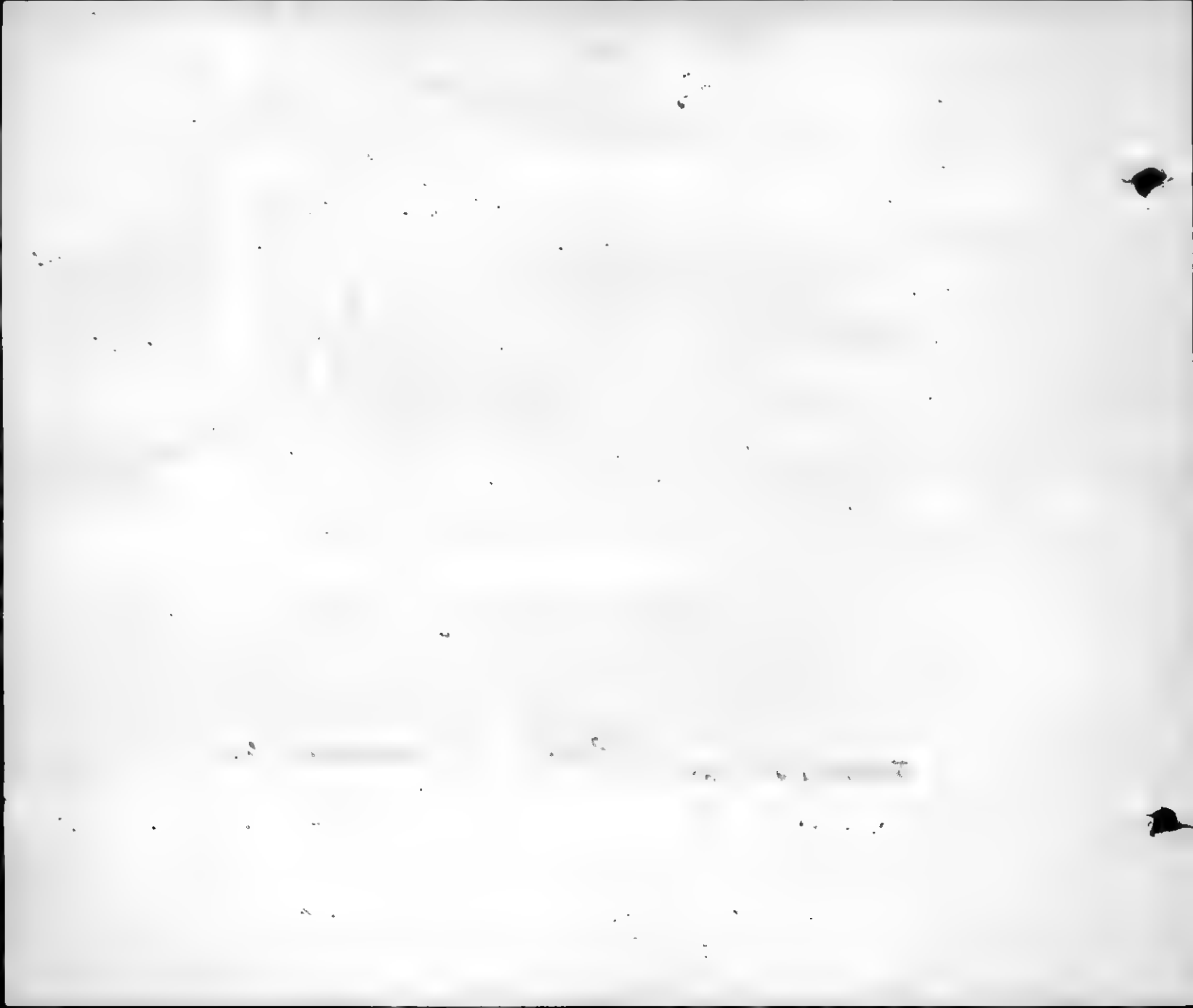
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

01738

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>127 Eastern Blvd. (21)</b>		d. STREET ADDRESS <b>127 Eastern Blvd. (21)</b>	
3. NAME OF DECEASED (Type or print) First <b>STEVE</b> Middle <b>STANLEY</b> Last		4. DATE OF DEATH Month <b>FEB.</b> Day <b>1</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1889</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tire Stock Dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Lincoln, Neb.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charlie Stanley</b>		14. MOTHER'S MAIDEN NAME <b>Mary ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>Emma Stanley 127 Eastern Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thromboses</b> <b>332x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Atherosclerosis</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis H.D. hypertension 28 &amp; 9</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9-25, 1957</b> to <b>JANUARY 21, 1960</b> that I last saw the deceased alive on <b>JANUARY 21, 1960</b> and that death occurred at <b>11 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Jack Wexler</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>M.D. 2502 Eutaw Place-Balto. 17, Md. 2/4/60</b>	
PHYSICIAN'S NAME (Type) <b>Jack Wexler, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>	22b. DATE THEREOF <b>2-6-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Moreland's Memorial</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John S. Connelly</b>		24a. REC'D BY REGISTRAR <b>FEB 8 '60</b>	
ADDRESS <b>418 Eastern Blvd.</b>		24b. REGISTRAR'S SIGNATURE <b>James S. Munn</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

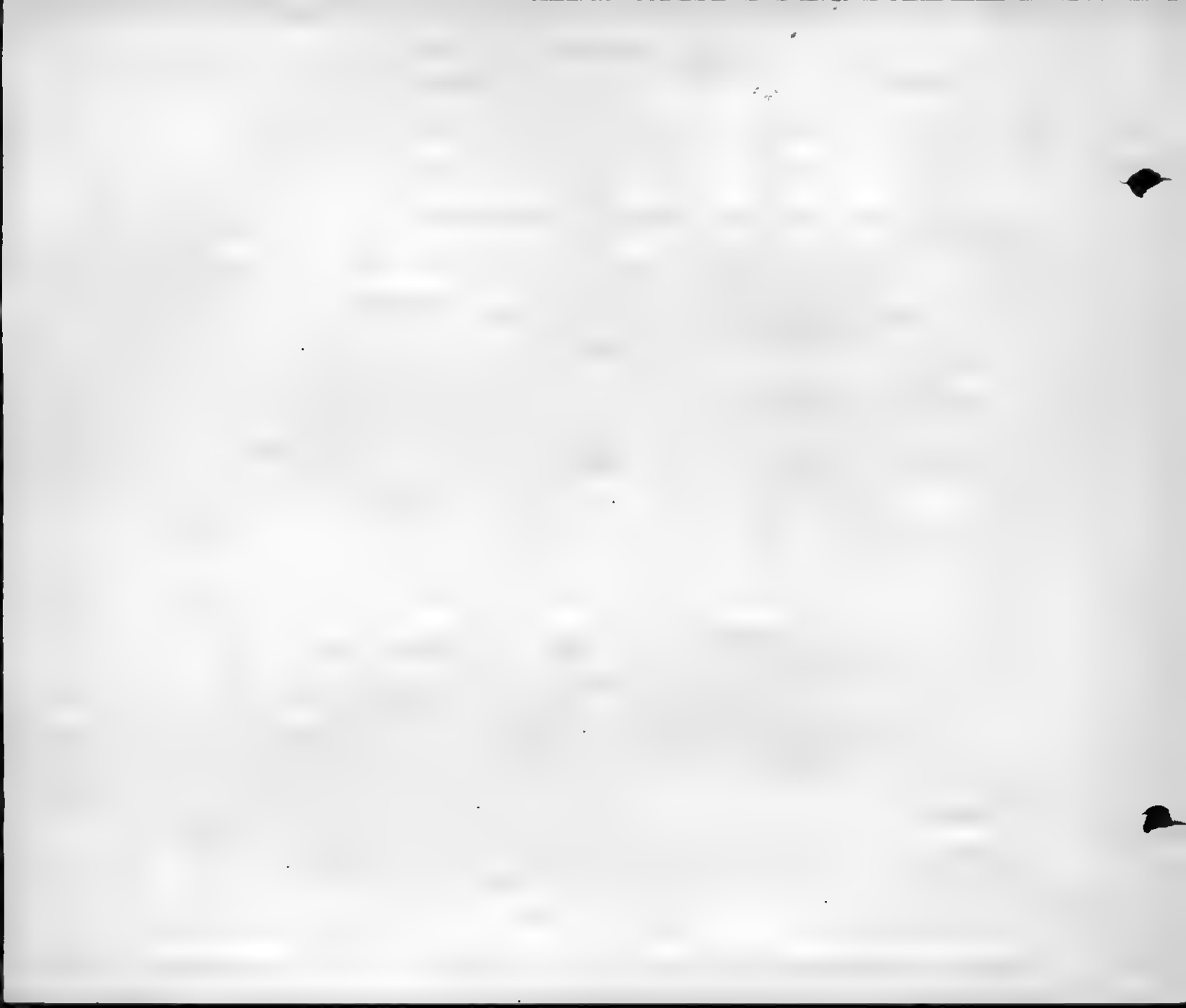
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1748 CERTIFICATE OF DEATH

01739

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
c. LENGTH OF STAY IN 1b <u>10 days</u>		d. STREET ADDRESS <u>2208 ASHTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUMMIT NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>H.</u> Last <u>STRICKER</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 14, 1978</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LINSMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WESTERN UNION</u>	9. AGE (In years last birthday) <u>81</u> yrs IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>ELI STRICKER</u>		14. MOTHER'S MAIDEN NAME <u>CLARA DAY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-10-1149</u>	
17. INFORMANT <u>MRS. GEO. W. FOWLER</u>		Address <u>2208 ASHTON ST. BALTO. 23, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cataracts Bilat postoperative Right.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1/29/60</u>	20f. (City or town) <u>2/7/60</u> (County) (State)
21. I certify that I attended the deceased from <u>1/29/60</u> to <u>2/7/60</u> that I last saw the deceased alive on <u>1/29/60</u> and that death occurred at <u>10:20 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. E. McGloth</u> M.D.		ADDRESS (Street, city or town, state) <u>1303 Frederick Rd</u> DATE SIGNED <u>2/4/60</u>	
PHYSICIAN'S NAME (Type) <u>W. E. McGloth</u>		<u>Catonville 28md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/11/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cem.</u>	22d. LOCATION (City, town, or county) <u>BALTO.</u> (State) <u>MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Truman School</u> ADDRESS <u>3512 Frederick Ave. (29)</u>		24a. REC'D BY REGISTRAR <u>FEB 11 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur J. Howard</u>



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been entered by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

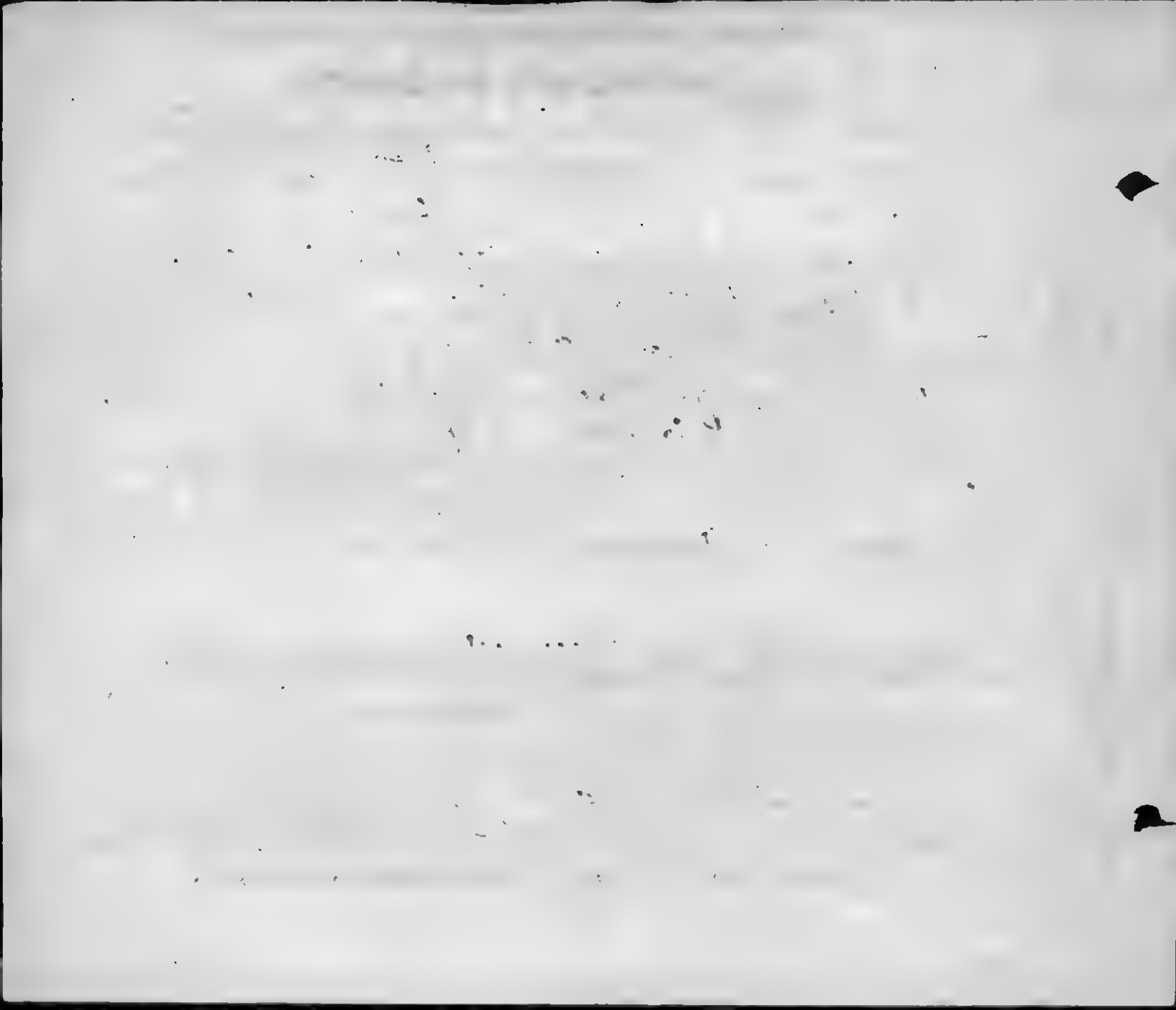
01740

## CERTIFICATE OF DEATH

1748

Reg. Dist. No. 32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTO. CO</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Mt. Wilson</u>		LENGTH OF STAY (in this place) <u>7 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ESSEX</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural, give location) <u>1021 MIDDLESEX ROAD.</u>			
3. NAME OF DECEASED (Type or Print) <u>MARY REIORDAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 17 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>OCT 12 1890</u>	
9. AGE last birthday <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>TENNESSEE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>BARTHALEMEW REIORDAN</u>		14. MOTHER'S MAIDEN NAME <u>? ? ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>403-05-22910</u>		17. INFORMANT & ADDRESS <u>Hospital Records Mt. Wilson State Hospital</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
X IMMEDIATE CAUSE (A) <u>PULMONARY TUBERCULOSIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 YEARS</u>			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>ARTERIO-SCLEROTIC CARDIO VASCULAR Dis.</u>				<u>uncertain</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/10</u> , 19 <u>60</u> , to <u>2/17</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/17</u> , 19 <u>60</u> , and that death occurred at <u>10:10 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wm. Newcomer, M.D. Superintendent, Mt. Wilson, Md.</u>				ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-20-60</u>		NAME OF CEMETERY OR CREMATORY <u>Belair Memorial Garden, Harford Co.</u>		LOCATION (City, town, or county) (State) <u>Md.</u>	
24. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>		REGISTRAR'S SIGNATURE <u>William S. Klaus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly</u>		ADDRESS <u>Essex 21, Md.</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

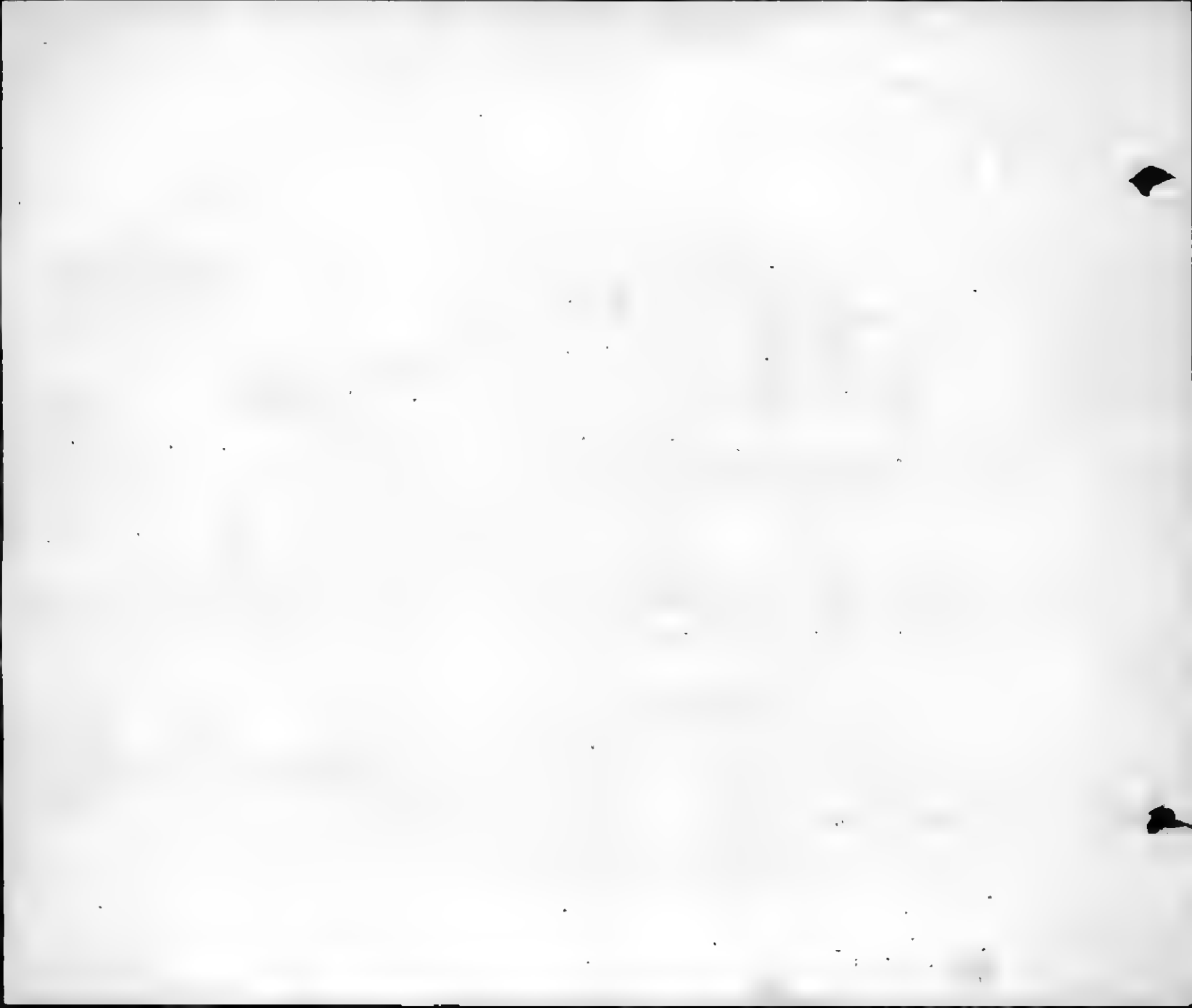
1760 Film G257 2-29-60 et  
**CERTIFICATE OF DEATH**

01741

Reg. Dist. No.

<b>1 PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>30 months</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>STEVENS CARE HOME</u>				<b>2 USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE, 1</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE, 1</u> d. STREET ADDRESS <u>702 W. Hamburg St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3 NAME OF DECEASED</b> (Type or print) First Middle Last <u>Annie C. SWEET</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>Feb. 18 1960</u>				
<b>5 SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></b> <u>WIDOWED</u>			
<b>8. DATE OF BIRTH</b> <u>Aug 26, 1868</u>		<b>9. AGE (In years last birthday)</b> <u>91 yrs.</u>		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>DOMESTIC</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Unknown</u>					
<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown.</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> Address <u>Franklin SWEET 702 W. Hamburg St.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 452.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic CVD</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Kyphoscoliosis, severe</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m.		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that I attended the deceased from</b> <u>2/11</u> , 19 <u>60</u> , to <u>2/18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/17</u> , 19 <u>60</u> , and that death occurred at <u>10:15 P.M.</u> , from the causes and on the date stated above.					
<b>ACTUAL SIGNATURE</b> <u>James J. Nolan</u>		<b>ADDRESS</b> (Street, city or town, state) <u>1 Meadow Hill Ave</u>		<b>DATE SIGNED</b> <u>2/19/60</u>			
<b>PHYSICIAN'S NAME (Type)</b> <u>JAMES J. NOLAN</u>		<u>Baltimore 29, Md</u>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>2/22/60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>MEADOWRIDGE</u>			
<b>22d. LOCATION</b> (City, town, or county) (State) <u>ELKridge, Md.</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Geo. L. Schwab Funeral Home</u> <u>Francis W. Mullen 2101 Frederick Ave</u>					
<b>24a. REC'D BY REGISTRAR</b> DATE <u>FEB 23 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>W. S. K...</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove it from papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1751 CERTIFICATE OF DEATH

Reg. Dist. No.

01742

1. PLACE OF DEATH COUNTY <u>BALTO. CO.</u> <u>206 Potomac Ave.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>MARYLAND</u> b COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROSEDALE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X ROSEDALE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>206 POTOMAC AVE</u>				1 d STREET ADDRESS <u>206 POTOMAC AVE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Maida E. Tabeling</u>				4. DATE OF DEATH Month Day Year <u>Feb. 22 1960</u>			
5 SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>APRIL 29, 1884</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min <u>10</u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO - MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CONSTANTINE EBERDT</u>				14 MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16 SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT - <u>MAURICE EBERDT</u>		Address <u>206 POTOMAC AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>							<u>20 years</u>
DUE TO <u>420.1</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>Coronary arteriosclerosis</u>							<u>1 1/2 hrs.</u>
(c) <u>Coronary Generalized/arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
<u>Pernicious Anemia</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>Feb. 18 1960</u> to <u>Feb. 22 1960</u> , that I last saw the deceased alive on <u>February 22 1960</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodore E. Evans</u>				ADDRESS (Street, city or town, state) <u>9660 Belair Road</u>			
PHYSICIAN'S NAME (Type) <u>Theodore E. Evans, M.D.</u>				DATE SIGNED <u>Baltimore 6, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-25-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAKLAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO COUNTY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.F. Hoffmann</u>				ADDRESS <u>3218 Hudson St.</u>		24a. REC'D BY REGISTRAR DATE <u>23 60</u>	
				24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>			

MEDICAL CERTIFICATION

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1752

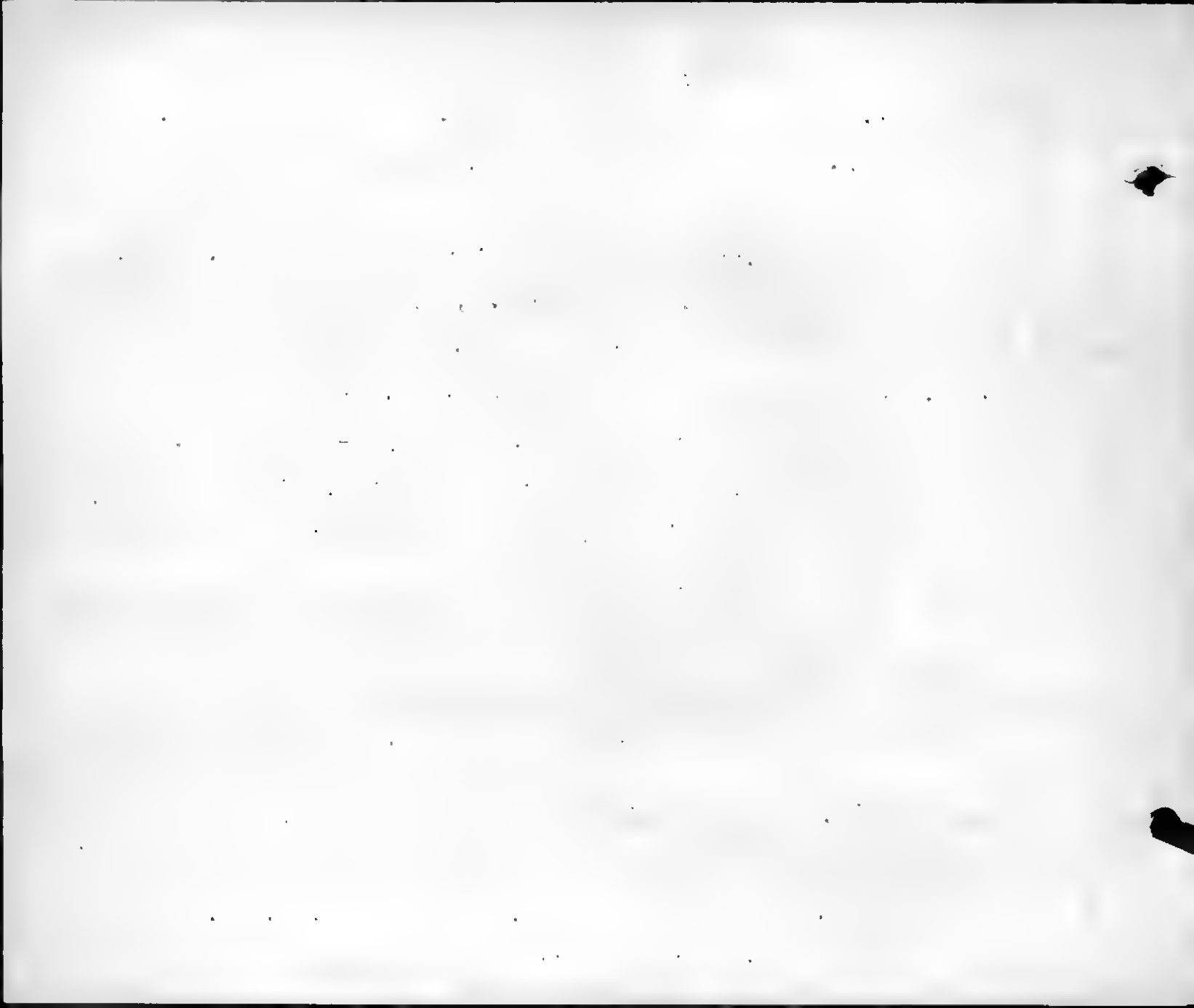
CERTIFICATE OF DEATH

01743

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodstock</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodstock</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Olive</b> Middle <b>Jane</b> Last <b>Taylor</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>15</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 27, 1889</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min <b>70</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John H. Wade</b>		14. MOTHER'S MAIDEN NAME <b>Margaret E. Niedert</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Mrs. Henry Tregoe - Old Court Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Thrombosis</b> <b>32X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Thrombosis, Unilateral</b> DUE TO (c) <b>Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1959 to 15 Jan to</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 34</b> , 19, to <b>15 Jan</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>15 Jan</b> , 19 <b>60</b> , and that death occurred at <b>1:00 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Harold E. Hall</b> M.D.		ADDRESS (Street, city or town, state) <b>A. J. Hall, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Harold E. Hall</b>		DATE <b>15 Jan 60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/18/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>A. A. Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lieberman &amp; Sons - Balto 17</b>		24a. REC'D BY REGISTRAR <b>Feb 18 '60</b>	
ADDRESS <b>Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hance</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01744

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> <u>1753</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY IN TB <u>LEFE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON 55</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>109 E. CHESTNUT AVE</u>		d. STREET ADDRESS <u>109 E. CHESTNUT AVE</u>	
3. NAME OF DECEASED (Type or print) <u>BESSIE E. THOMAS</u>		4. DATE OF DEATH <u>2/8/60</u> Month <u>2</u> Day <u>8</u> Year <u>19</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9 1928</u> 9. AGE (in years last birthday) <u>31</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE THOMAS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>FANNIE THOMAS</u>		Address <u>413 W. A. AVE. TOWSON</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chokehold</u> DUE TO <u>Chokehold</u> Conditions, if any, which gave rise to immediate cause (b) <u>Sudden</u> (c) stating the underlying cause lost. <u>Sudden</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Caught in 2nd floor room in burning building</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>10</u> <u>0</u> <u>30</u> <u>PM</u> <u>2-8-60</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Towson</u> (County) <u>BALTO.</u> (State) <u>MD.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles E. Thomas</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles E. Thomas</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/10/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest</u>	22d. LOCATION (City, town, or county) <u>BALTO.</u> (State) <u>MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Thomas</u>		24a. REC'D BY REGISTRAR <u>FEB 10 '60</u>	
ADDRESS <u>1741 M. St. Balto.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

MEDICAL CERTIFICATION

TO DEPUTY: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



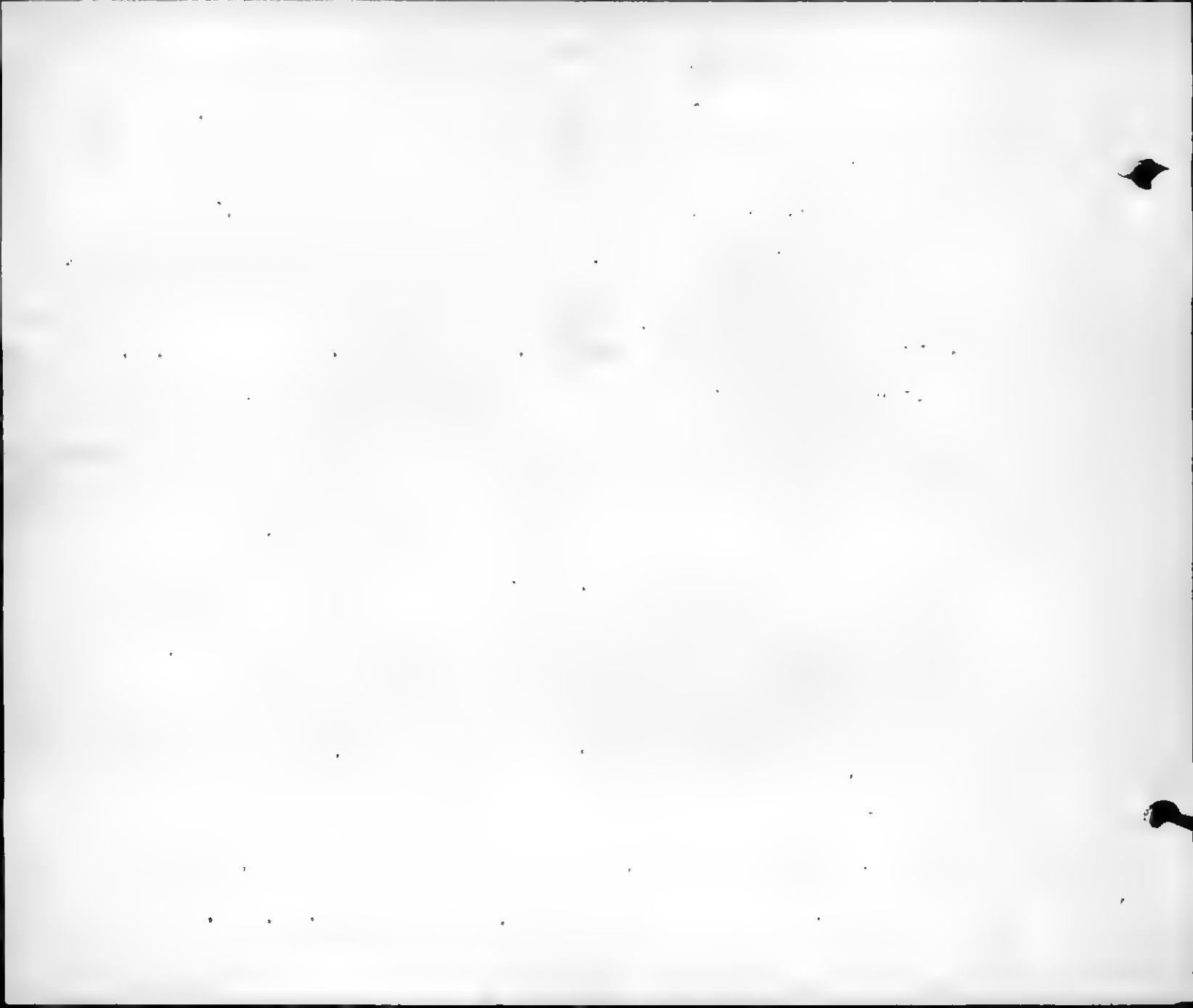
1754  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>2m and 2days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>		d. STREET ADDRESS <b>2919 Georgia Avenue-Balto.27</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>F.</b> Last <b>Timme</b>		4. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 6, 1899</b>
9. AGE (In years last birthday) <b>60</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>genl. manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Packing Austin Peanut Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown Louis Timme</b>		14. MOTHER'S MAIDEN NAME <b>Unknown unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b> <b>4221</b> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 9, 1959</b> to <b>Feb. 11, 1960</b> that I last saw the deceased alive on <b>Feb. 11, 1960</b> , and that death occurred at <b>7:20am</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachser</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 2-11-60</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachser, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATON, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/15/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Landon Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Walker &amp; Sons - Balto.</b>		24a. RECEIVED BY REGISTRAR DATE <b>FEB 15 60</b>	
24b. REGISTRAR'S SIGNATURE <b>Carol A. Wynn</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.









CERTIFICATE OF DEATH

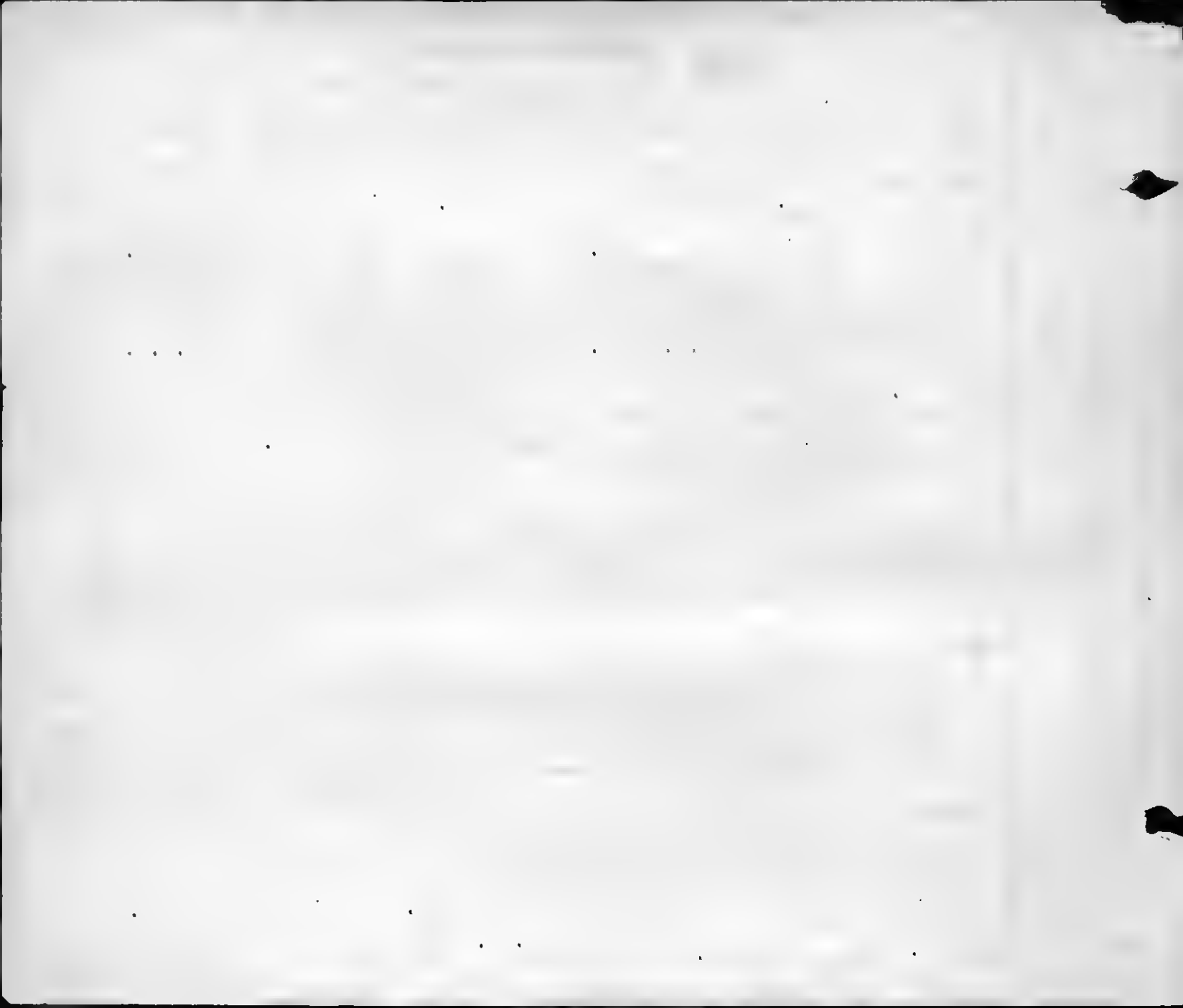
Reg. Dist. No.

1756

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Essex</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Essex</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7626 G. Doolittle Road</i>		d. STREET ADDRESS <i>7626 G. Doolittle Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Denis</i> Middle <i>K.</i> Last <i>Touhey</i>		4. DATE OF DEATH Month <i>February</i> Day <i>8.</i> Year <i>19 60</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/24/87</i>
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Storekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U. S. Gov't.</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Denis K. Touhey</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Lynch</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <i>yes WW I</i>		16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Margaret Touhey</i> Address <i>7626 G. Doolittle Road</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Hypertension</i> DUE TO (c) <i>Coronary Sclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>7 yr.</i> <i>7 yr.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Feb. 1953</i> , to <i>Feb. 8, 1960</i> , that I last saw the deceased alive on <i>Feb. 8, 1960</i> , and that death occurred at <i>5:15 P. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>David Schneider</i>		ADDRESS (Street, city or town, state) <i>1101 N. Wilton ave. Baltimore, Md.</i>	
PHYSICIAN'S NAME (Type) <i>David Schneider, M.D.</i>		DATE SIGNED <i>Feb. 12 '60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2/12/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Moran</i>		ADDRESS <i>3000 E. Baltimore Street Balto. Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>FEB 12 '60</i>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



1757

1757

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

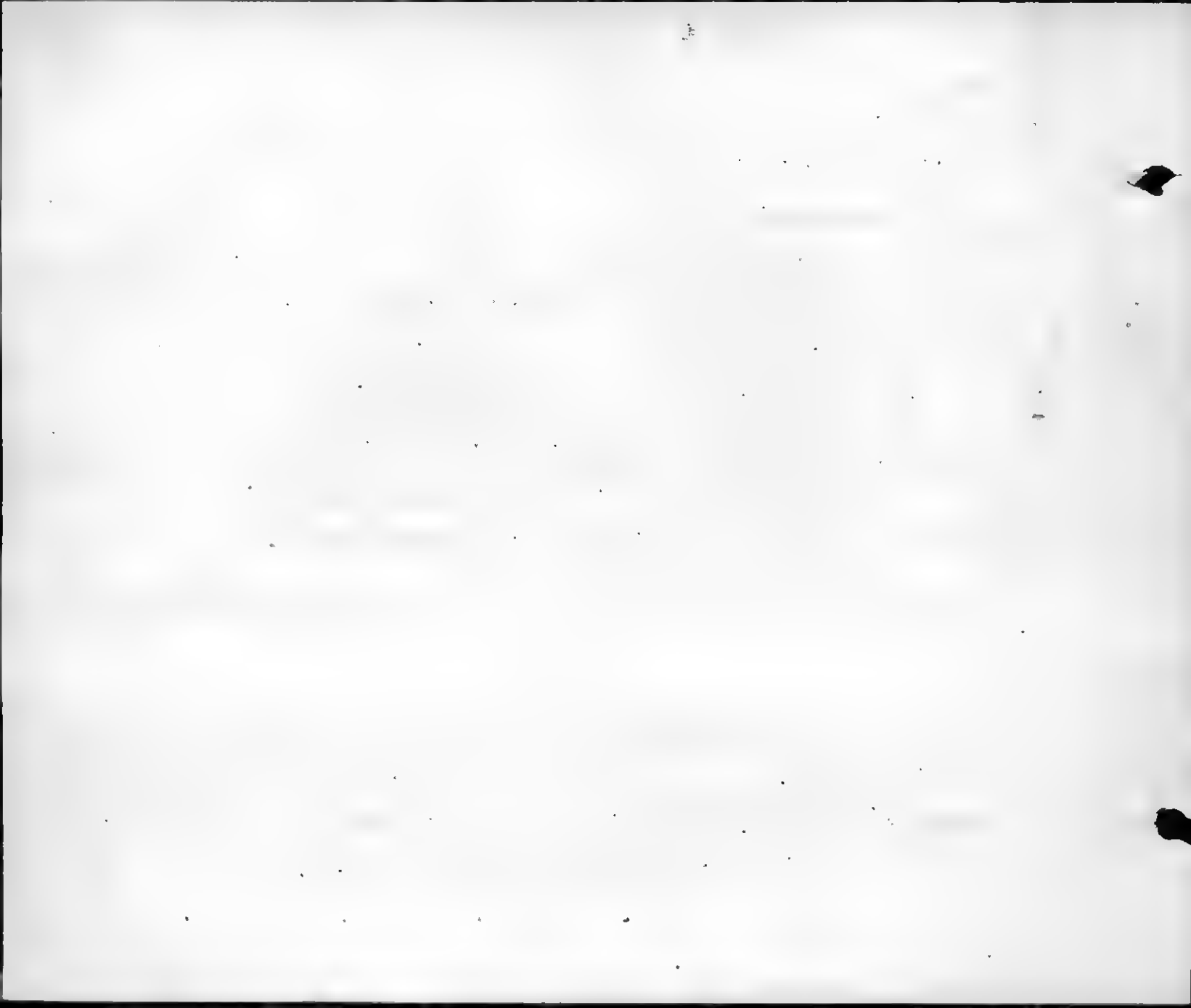
01748

1. PLACE OF DEATH a. COUNTY <u>Baltimore,</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sudbrook Park, Pikesville</u> c. LENGTH OF STAY IN Tb <u>165 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>505 Sudbrook Lane</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>505 Sudbrook Lane, Pikesville, 8,</u> d. STREET ADDRESS <u>505 Sudbrook Lane,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MILLARD</u> Middle <u>TOLSON</u> Last <u>TRABAND</u>		4. DATE OF DEATH Month <u>February</u> Day <u>28,</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 17, 1890</u>
9. AGE (In years last birthday) <u>69 yrs.</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Traveling Auditor B&amp;O RR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John H. Traband</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Tolson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>  </u>	
INFORMANT <u>Emily C. Traband</u>		Address <u>505 Sudbrook Lane, Balt. 8, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO <u>  </u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) *****	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <u>  </u> at work <input type="checkbox"/> or work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) *****		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that I attended the deceased from <u>  </u> , 1944, to <u>February</u> , 1960, that I last saw the deceased alive on <u>28 February</u> , 1960, and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5101 Gwynn Oak Ave.</u> DATE SIGNED <u>2/29/60</u>			
ACTUAL SIGNATURE <u>Millard T. Traband, Jr.</u> M.D. <u>5101 Gwynn Oak Ave.</u>		DATE SIGNED <u>2/29/60</u>	
PHYSICIAN'S NAME (Type) <u>Millard T. Traband, Jr. M.D.</u>		<u>Baltimore, 7, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/2/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickner &amp; Sons - Balt.</u>		24a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>  </u>	
DATE <u>MAR 1 '60</u>		DATE <u>  </u>	

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1758

## CERTIFICATE OF DEATH

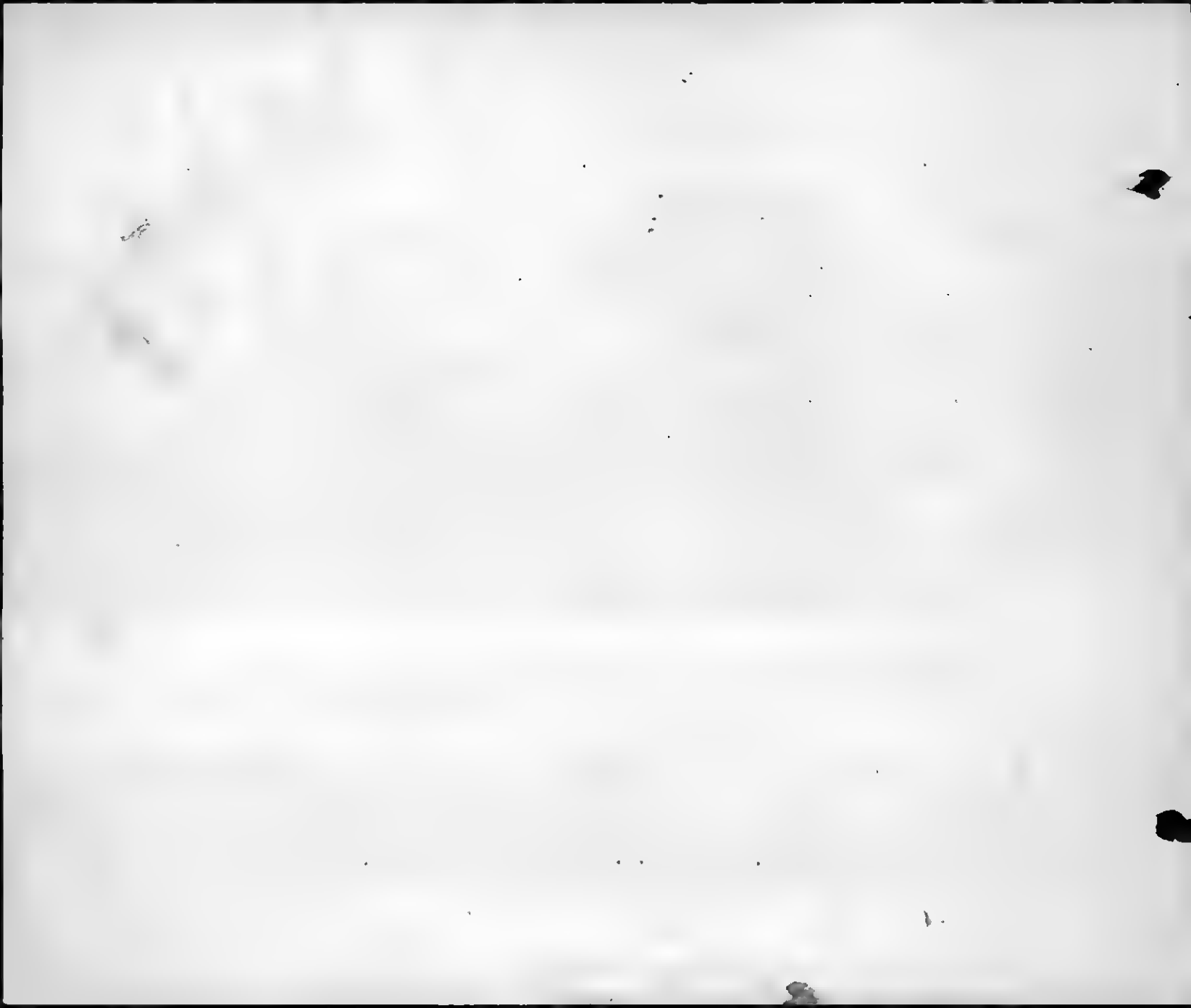
01749

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>none</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural: Towson</u>		c. LENGTH OF STAY IN 1b <u>7 Days.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City 3101.4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eudowood Sanatorium Towson 4, Maryland</u>				d. STREET ADDRESS <u>221 50th Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Tusznski</u> Last <u>Tusznski</u>				4. DATE OF DEATH Month <u>2</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/18/01</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>17</u>		IF UNDER 24 HRS Hours <u>17</u> Min. <u>19</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Water Watcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>John Tusznski</u>				14. MOTHER'S MAIDEN NAME <u>not known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>219-14-0993</u>		17. INFORMANT <u>Personal History Hospital Records, Eudowood Sanatorium</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> <u>202X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-10</u> , 19 <u>60</u> , to <u>2-17</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-17</u> , 19 <u>60</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Milton B. Kress</u> M.D.				Eudowood Sanatorium			
PHYSICIAN'S NAME (Type) <u>Milton B. Kress, M.D.</u>				Towson 4, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>2/19/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Ozazewski</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Thom &amp; H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.





1  
FOR STATE  
HEALTH DEPT.

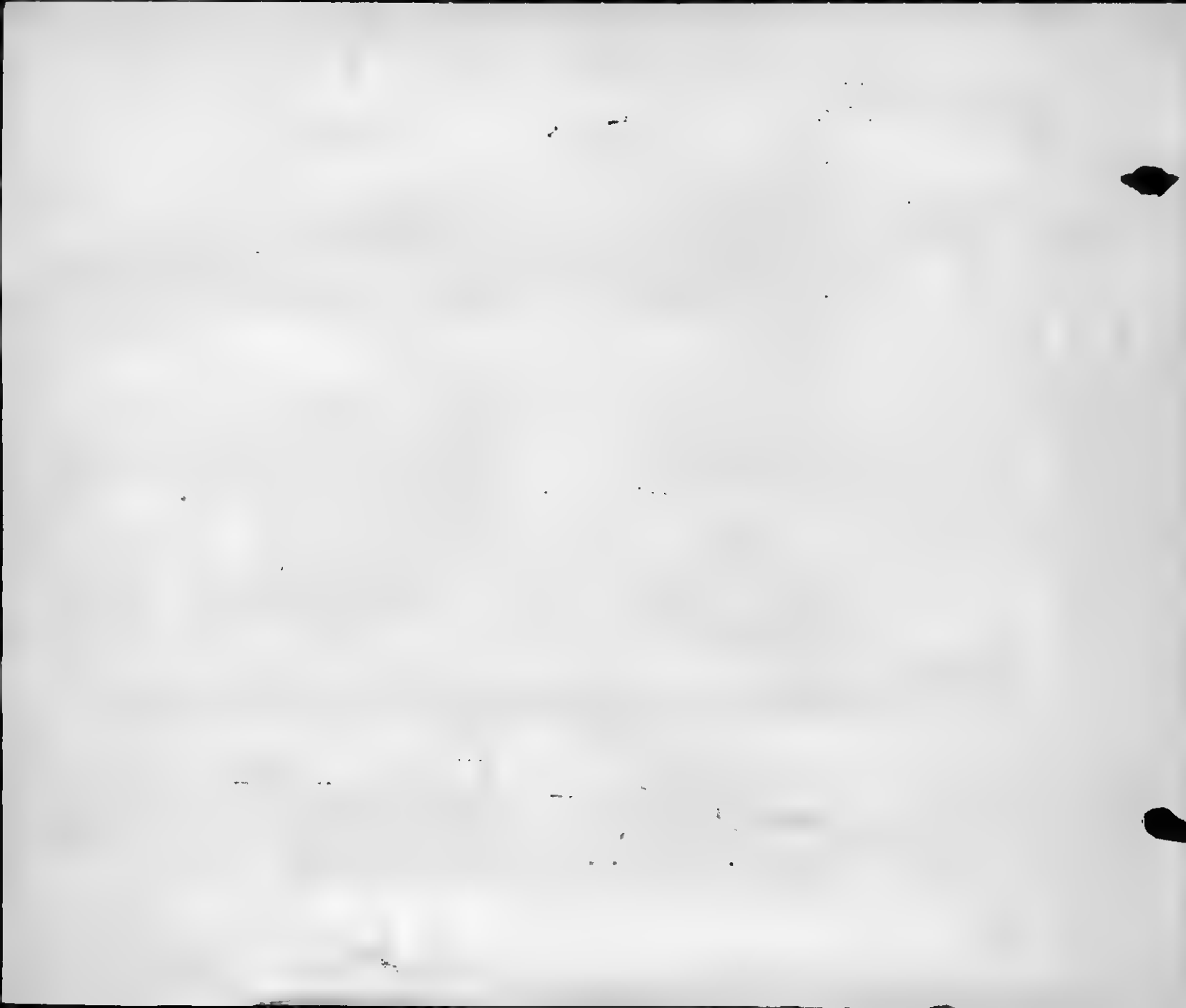
DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

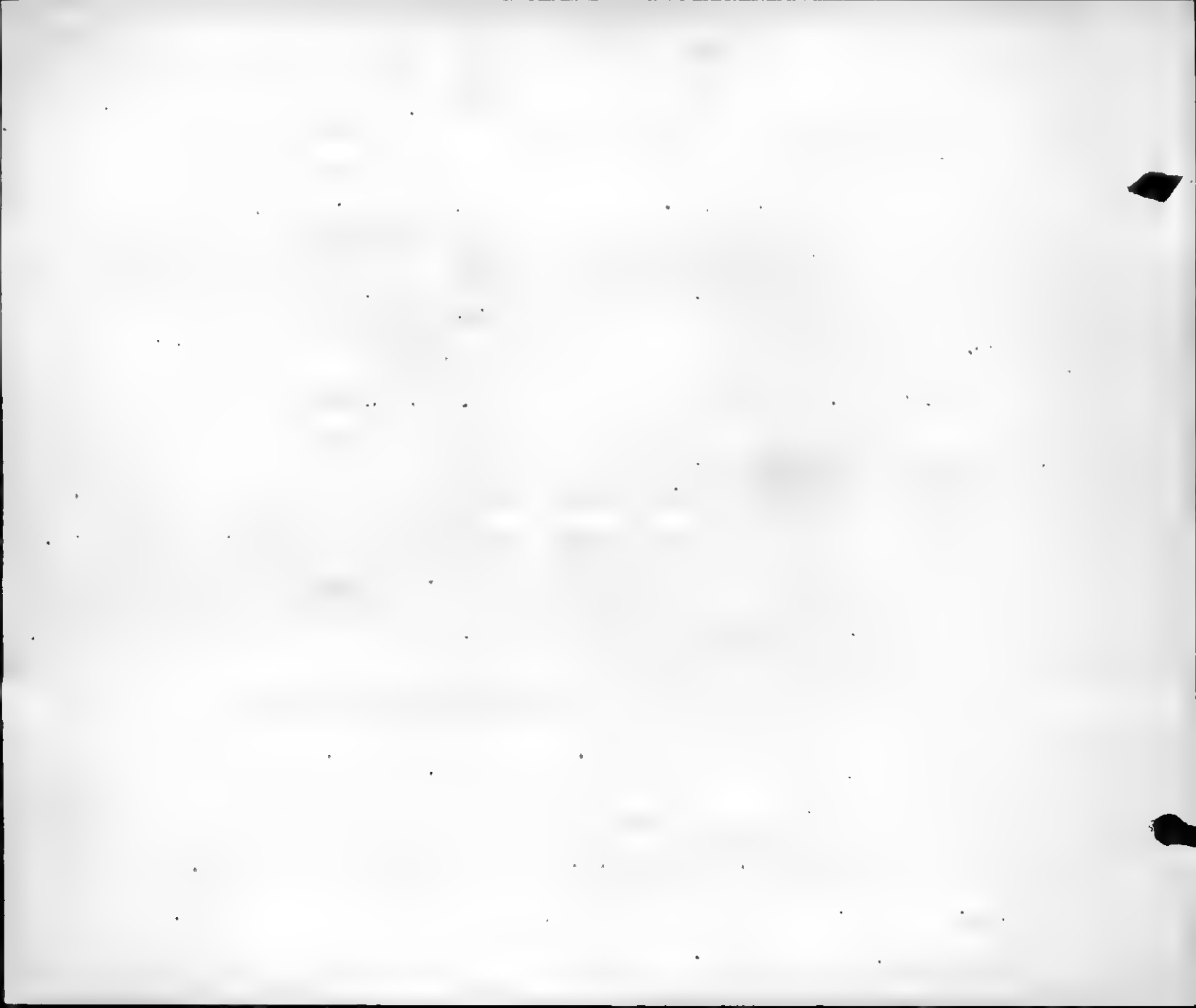
MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Res dance before admision) a. STATE <b>MARYLAND</b>		b. COUNTY <b>06719</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. LENGTH OF STAY IN 15		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Found Druid Ridge Cemetery</b>		d. STREET ADDRESS <b>UNKNOWN</b>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>UNKNOWN</b>		First Middle Last		4. DATE OF DEATH Month Day Year <b>February 11 19 60</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday) yrs. Months Days		IF UNDER 1 YEAR IF UNDER 24 HRS Hours Min. <b>5 (?)</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Decomposing Body; No Anatomical Cause of Death.</b> DUE TO (b) <b>15.3</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)					
ACTUAL SIGNATURE <b>Charles S. Petty</b>		M.D. <b>Charles S. Petty, M.D.</b>		DATE SIGNED <b>6/9/60</b>	
EXAMINER'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify)			
22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR ADDRESS		24a. REC'D BY REGISTRAR DATE <b>JUN 10 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Petty</b>	

9 ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓







1760

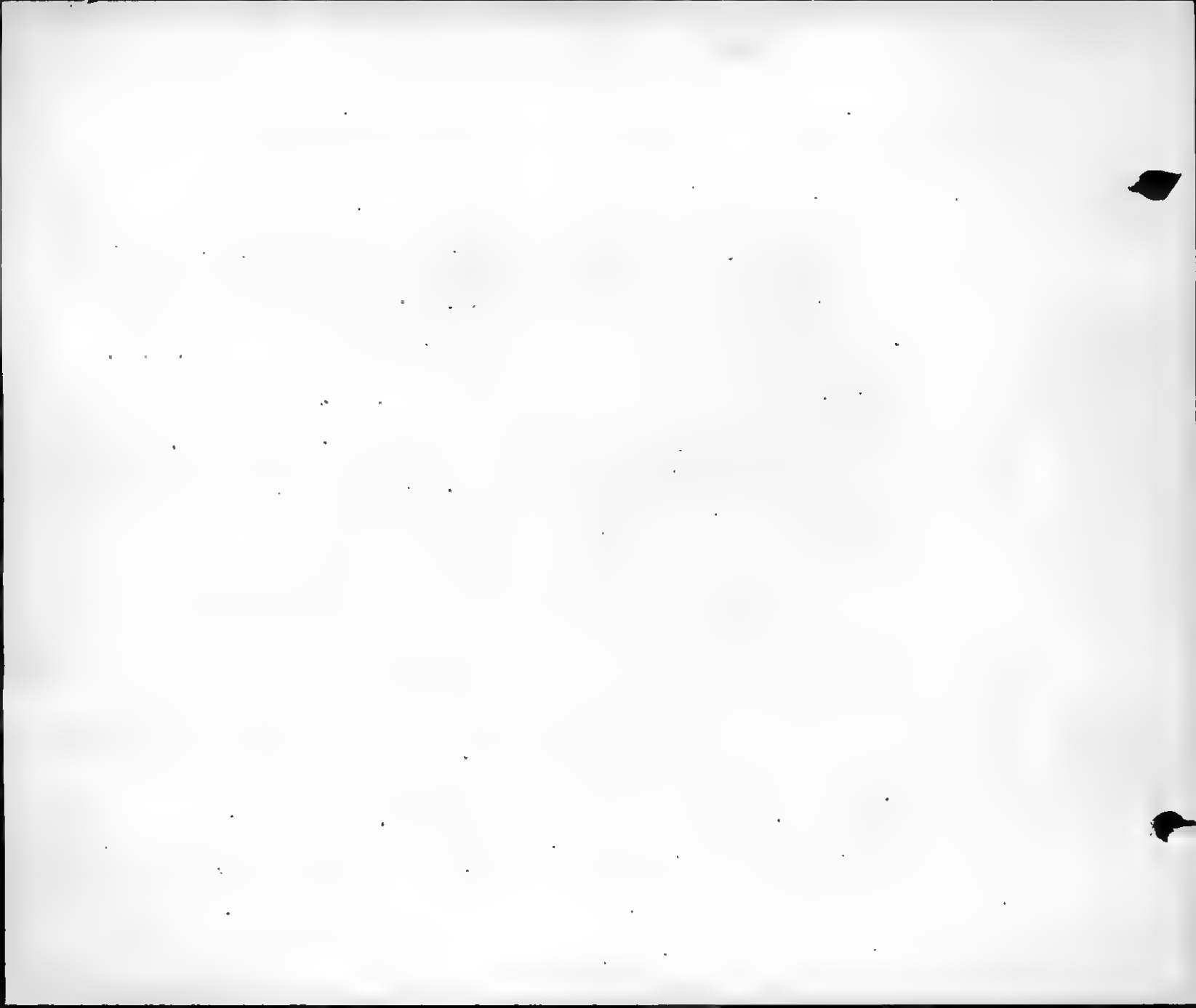
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Estelle</u> Middle <u>Chenoweth</u> Last <u>Vogt</u>		4. DATE OF DEATH Month <u>February</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 22, 1887</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife (Bookkeeper)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT. STORE. DOMESTIC</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Daniel M. Vogt</u>		14. MOTHER'S MAIDEN NAME <u>Clara G. Mann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>216-05-3367</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inferior. Cardio Vasc. Disease</u> 4. 1. 1. 1. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, General, Heart</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 16, 1960</u> to <u>2/28</u> , 19 <u>60</u> that I last saw the deceased alive on <u>2/28</u> , 19 <u>60</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Stella Wachslar</u>		M.D. <u>SPRING GROVE STATE HOSPITAL</u>	
PHYSICIAN'S NAME (Type) <u>STELLA WACHSLER</u>		<u>Catonsville 28, Maryland</u> <u>2/28/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-2-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LONDON TARK</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo L. Schwab Funeral Home</u> <u>Franklin or Miller 2101 Federal Ave</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 1 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

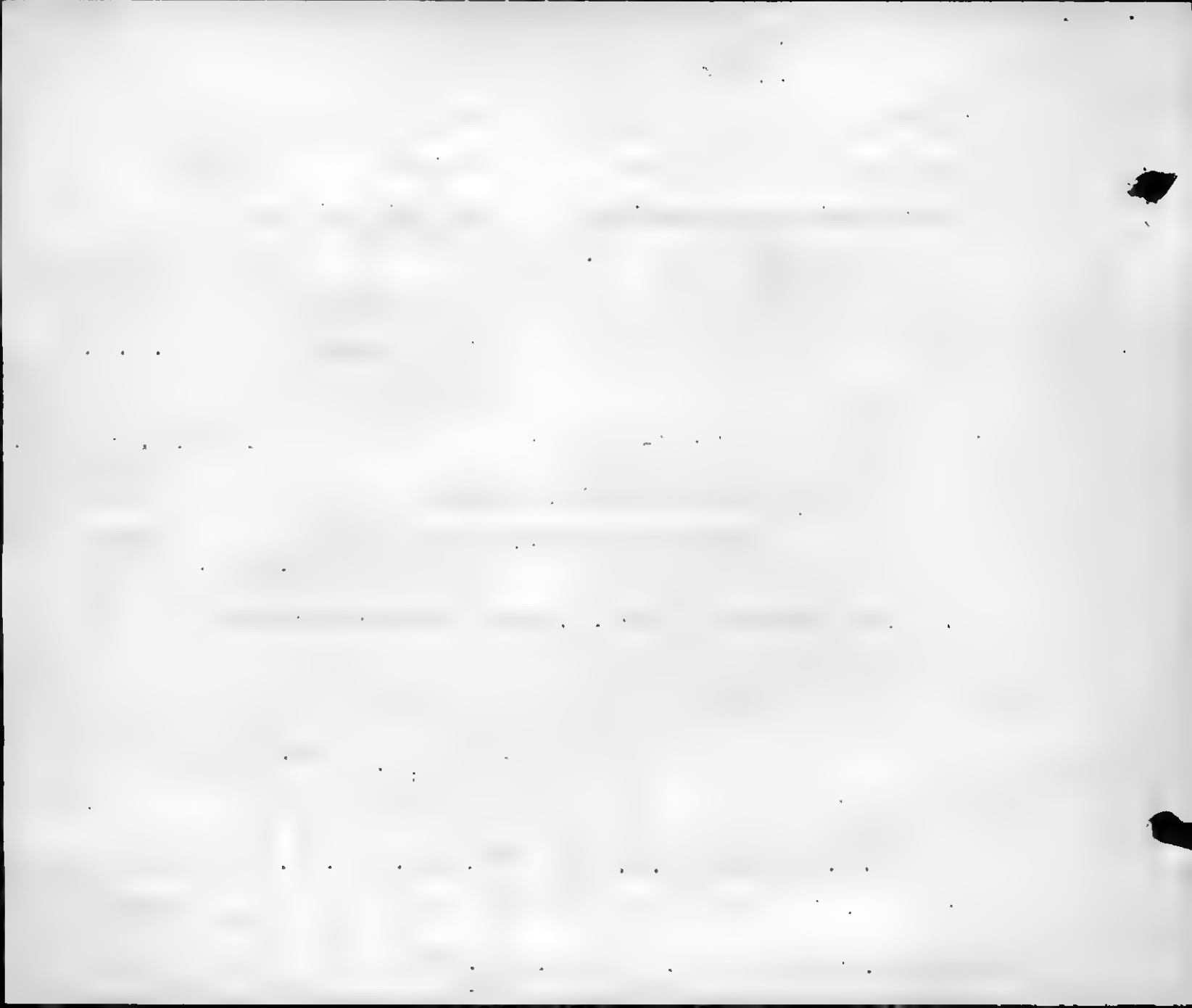


**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**1761** **CERTIFICATE OF DEATH**

01752

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>V</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			c. LENGTH OF STAY IN 1b <b>3 Days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (16)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>2211 Druid Hill Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>JOHN</b> First <b>H.</b> Middle <b>WALKER</b> Last		4. DATE OF DEATH <b>February</b> Month <b>8</b> Day <b>1960</b> Year		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 10, 1891</b>		9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Wilmot, Arkansas</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>John Walker</b>			
14. MOTHER'S MAIDEN NAME <b>Sarah Sanders</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> WW I			
16. SOCIAL SECURITY NO. <b>216-09-6027</b>		17. INFORMANT Address <b>Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, BILATERAL</b> <b>411X</b> <b>3000</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PULMONARY ABSCESSSES, MULTIPLE, BILATERAL</b> <b>3000</b> <b>PULMONARY EDEMA AND PULMONARY EMPHYSEMA, MARKED,</b> (c) <b>BILATERAL</b> INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>RECENT</b> <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. Cardiac hypertrophy, slight. 2. Benign prostatic hypertrophy</b> 19. WAS ALTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>W</b> (this hospital) attended the deceased from <b>Feb. 5</b> 19 <b>60</b> to <b>Feb. 8</b> 19 <b>60</b> , that <b>W</b> (we) last saw the deceased alive on <b>2/8/</b> 19 <b>60</b> , and that death occurred at <b>2:50 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <i>W. J. Pijanowski</i> <b>W. J. PIJANOWSKI, M. D.</b>				22b. DATE <b>2/9/60</b>		22c. PHYSICIAN'S NAME (Type) <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b>	
23a. BURIAL, CREMAT. OR REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/12/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore</b>		23d. LOCATION (City, town or county) (State) <b>Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips, 1808 N. Monroe St. Balto. 17</b>				25a. REC'D BY REGISTRAR <b>FEB 15 '60</b>		25b. REGISTRAR'S SIGNATURE <i>Carlton E. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Ans. by phone (Mr. MacNabb) 4-7-60 et

1762

## CERTIFICATE OF DEATH

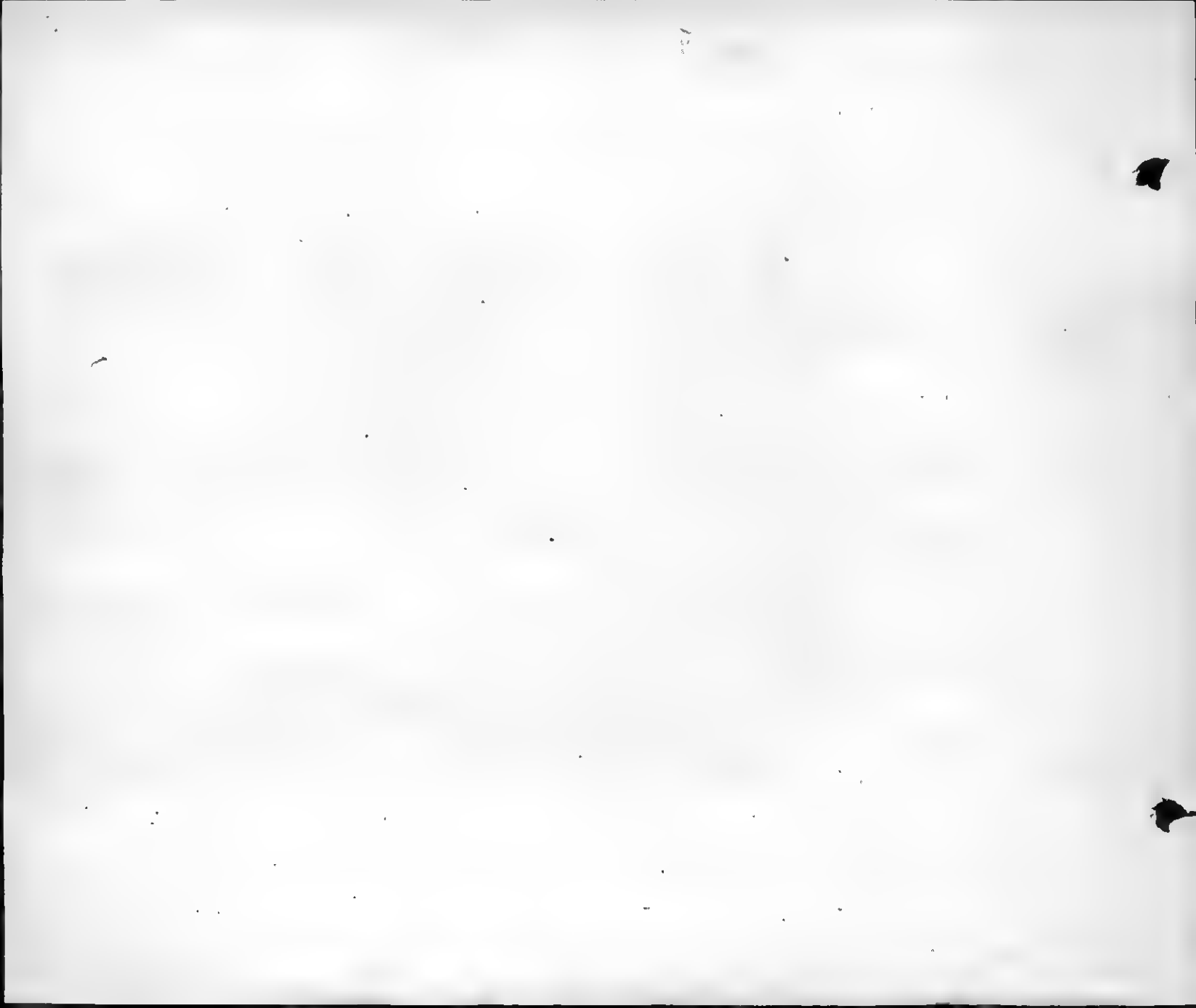
03054

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>24 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>-</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>4201 Pennington Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Wall</b> Last <b>Wall</b>		4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) <b>70?</b> yrs.		10. IF UNDER 1 YEAR Months <b>70?</b> Days <b>70?</b> Hours <b>70?</b> Min. <b>70?</b>	11. IF UNDER 24 HRS Hours <b>70?</b> Min. <b>70?</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>?</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>424-01-684</b>	
17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 26, 1960</b> to <b>Feb. 20, 1960</b> that I last saw the deceased alive on <b>Feb. 20, 1960</b> and that death occurred at <b>11:20 a.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>2-22-60</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		City or town, state <b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/4/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Peters</b>	22d. LOCATION (City, town, or county) (State) <b>Bethesda, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>MacNabb &amp; Son Co</b> ADDRESS <b>Catonsville</b>		24a. REC'D BY REGISTRAR DATE <b>APR 5 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>5 TOWSON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1403 GATESHEAD ROAD</b>		d. STREET ADDRESS <b>1403 GATESHEAD ROAD</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>RALPH</b> Middle <b>H.</b> Last <b>WALLACE, SR.</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>26</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 1, 1874</b>
9. AGE (In years last birthday) <b>85</b> yrs		IF UNDER 1 YEAR Months <b>85</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	11. BIRTHPLACE (State or foreign country) <b>Maine</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Joseph L. Wallace</b>		14. MOTHER'S MAIDEN NAME <b>Elmira ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>- -</b>	
17. INFORMANT <b>JOSEPH L. WALLACE, TOWSON, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>434.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Failure</b> DUE TO (c) <b>6 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b> <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 19, 1959</b> to <b>Feb 26, 1960</b> that I last saw the deceased alive on <b>Feb 26, 1960</b> and that death occurred at <b>11:30 PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George T. Gilman, M.D.</b>		DATE SIGNED <b>2/29/60</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal/Burial Feb. 29, 1960</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Rosedale Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Orange, New Jersey</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns Sons, Towson, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 3 '60</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>William S. Hanna</b>	



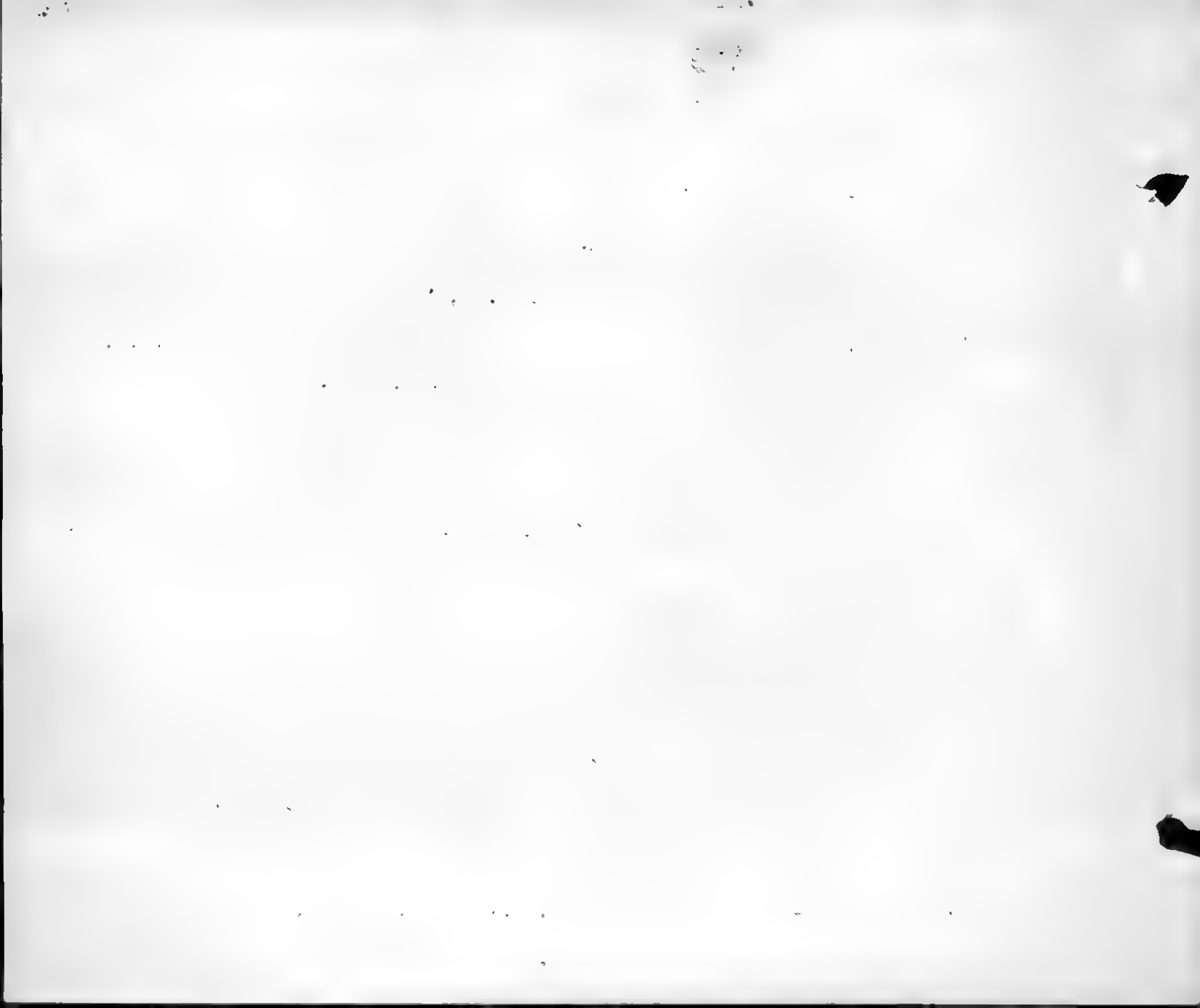
## 1558 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7811 Fairgreen Road</b>		e. STREET ADDRESS <b>12938 Yorkway</b>	
3. NAME OF DECEASED (Type or print) <b>John VanLieu Walton</b>		4. DATE OF DEATH Month <b>2</b> Day <b>6</b> Year <b>1960</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 23, 1886</b>
9. AGE (In years last birthday) <b>73</b>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ret'd Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John William Walton</b>		14. MOTHER'S MAIDEN NAME <b>Lincoln Hampton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO <b>Hypertensive Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>severe</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>			
19. INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August 2, 1959</b> to <b>2-6, 1960</b> , that I last saw the deceased alive on <b>2-6-1960</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Juri Hinnu</b>		ADDRESS (Street, city or town, state) <b>2900 Dunbar Rd, Balto 22</b>	
PHYSICIAN'S NAME (Type) <b>JURI HINNO</b>		DATE SIGNED <b>2-7-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2-10-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Betheda Meth. Church Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Gist, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 9 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)  
15M 9/5B



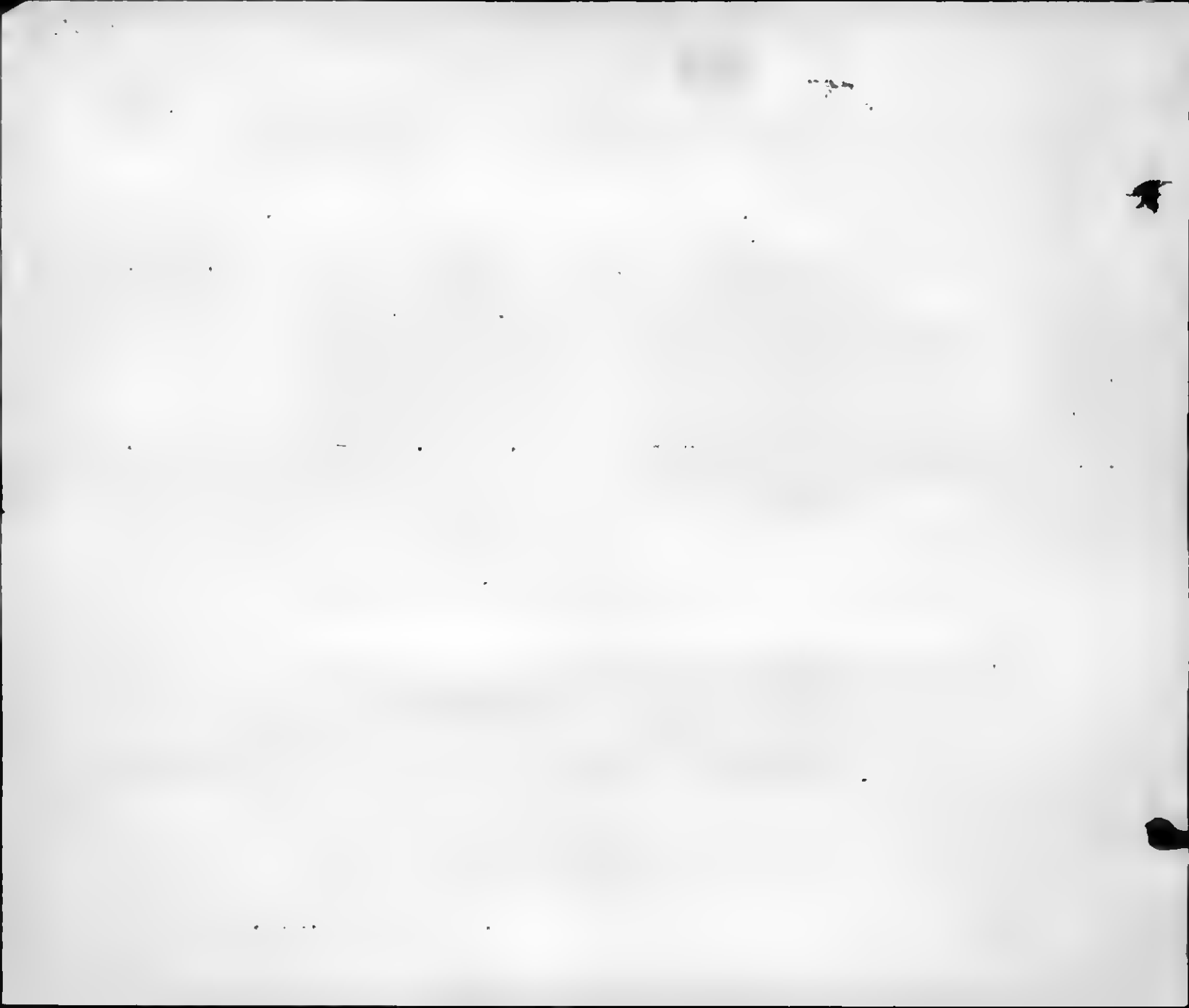
## 1559 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>				c. LENGTH OF STAY IN 1b <b>53 Dundalk</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>238 Patapsco Ave.</b>				d. STREET ADDRESS <b>238 Patapsco Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CARROLL</b> Middle <b>C.</b> Last <b>WARD</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>14</b> Year <b>19 60</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 15, 1878</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Accountant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Merchants Club</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
13. FATHER'S NAME <b>Richard Ward</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Fitchette</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-05-0439</b>		17. INFORMANT Address <b>Mrs. Ella B. Ward - 238 Patapsco Ave. #22</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>gonorrhea</b> DUE TO (c) <b>Bilateral kerneal &amp; senility</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b> <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>4-6</b> , 19 <b>55</b> , to <b>2-14</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>2-14</b> , 19 <b>60</b> , and that death occurred at <b>10 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Eugene F. Newy</b>				ADDRESS (Street, city or town, state) <b>7001 Morrison Tr. Rd</b>			
PHYSICIAN'S NAME (Type) <b>Eugene F. Newy M.D.</b>				DATE SIGNED <b>2-14-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/17/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jim F. Lickner &amp; Son - Balto</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 17 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>in transit</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Painter Mill Road</b>		d. STREET ADDRESS <b>Finksburg R.D.1</b>	
3. NAME OF DECEASED (Type or print) First <b>Patricia</b> Middle <b>Dianne</b> Last <b>Webb</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 15, 1953</b>
9. AGE (In years last birthday) <b>6</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School girl</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Elkton, Kentucky</b>	
11. BIRTHPLACE (State or foreign country) <b>Elkton, Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Burnett A. Webb</b>		14. MOTHER'S MAIDEN NAME <b>Mary Glenn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Burnett A. Webb</b>		Address <b>R.F.D.1 Finksburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Compound Fracture of skull</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b> INTERVAL BETWEEN ONSET AND DEATH <b>20 min.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>auto overturned &amp; crashed into utility pole</b>	
20c. TIME OF INJURY Hour <b>1:30</b> P. M. <b>2-21-60</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Painters Mill Rd., Owings Mills, Balto., Md.</b>	
20f. (City or town) (County) (State) <b>Owings Mills, Balto., Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>D. D. Copley</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>D. D. Copley, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 23, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Memorial Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Finksburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Luther Haight, Sykesville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 29 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Luther H. Haight</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01757

1765

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PENNSYLVANIA</u> b. COUNTY <u>CHAMBERBURG</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>521 E. CHAMBERBURG AVE</u>		c. LENGTH OF STAY IN 1b <u>13 MONTHS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHAMBERBURG</u>		7	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RIVERVIEW NURSING HOME</u>				d. STREET ADDRESS <u>308 E. CHAMBER ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>EDWIN</u> Last <u>WEBER</u>				4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/20/1875</u>	
9. AGE (in years lost birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>2</u> Hours <u>1</u> Min. <u>6</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL PRINCIPAL</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL PRINCIPAL</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	
13. FATHER'S NAME <u>GEORGE WEBER</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH WEBER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT <u>MR. ANN WEBER</u>		Address <u>3415 COTTAGE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>18 MONTH AGO</u> (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>3 MINUTE</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/12/57</u> to <u>1/2/60</u> that (I) (we) last saw the deceased alive on <u>1/1/60</u> and that death occurred at <u>HOME</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Edwin H. Hight</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWIN H. HIGHT, M.D.</u>				22d. ADDRESS <u>8204 LIBERTY RD, BALTO, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2-5-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Morningside</u>		23d. LOCATION (City, town, or county) (State) <u>Real Beach, PA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Hight, Jr., S.M.D.</u>				25a. REC'D BY REGISTRAR <u>FEB 8 60</u>		25b. REGISTRAR'S SIGNATURE <u>Conner S. Hanna</u>	

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1768  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

01758

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Golden Ring</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Georgianna Weinreich</b>		4. DATE OF DEATH Month Day Year <b>Feb 7 1960 19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15 1917</b>
9. AGE (In years last birthday) <b>42</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<b>at home</b>		<b>Maryland</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William T. Whiteley</b>		14. MOTHER'S MAIDEN NAME <b>Mary Kirby</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>William Weinreich 2314 Gross Ave</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral metastases</b> <b>170X</b> DUE TO (b) <b>Carcinoma of Breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1959</b> to <b>Feb 7 1960</b> , that (I) (we) last saw the deceased alive on <b>Feb 7 1960</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above			
22a. SIGNATURE <b>Louis Semenovff</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>LOUIS SEMENOFF</b>		22d. ADDRESS <b>2108 CREMS RD, BAC TO 20, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>Feb 10/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Co</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Malrich Funeral Home 2112 Dundalk Ave Dundalk</b>		25a. REC'D BY REGISTRAR <b>FEB 10 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



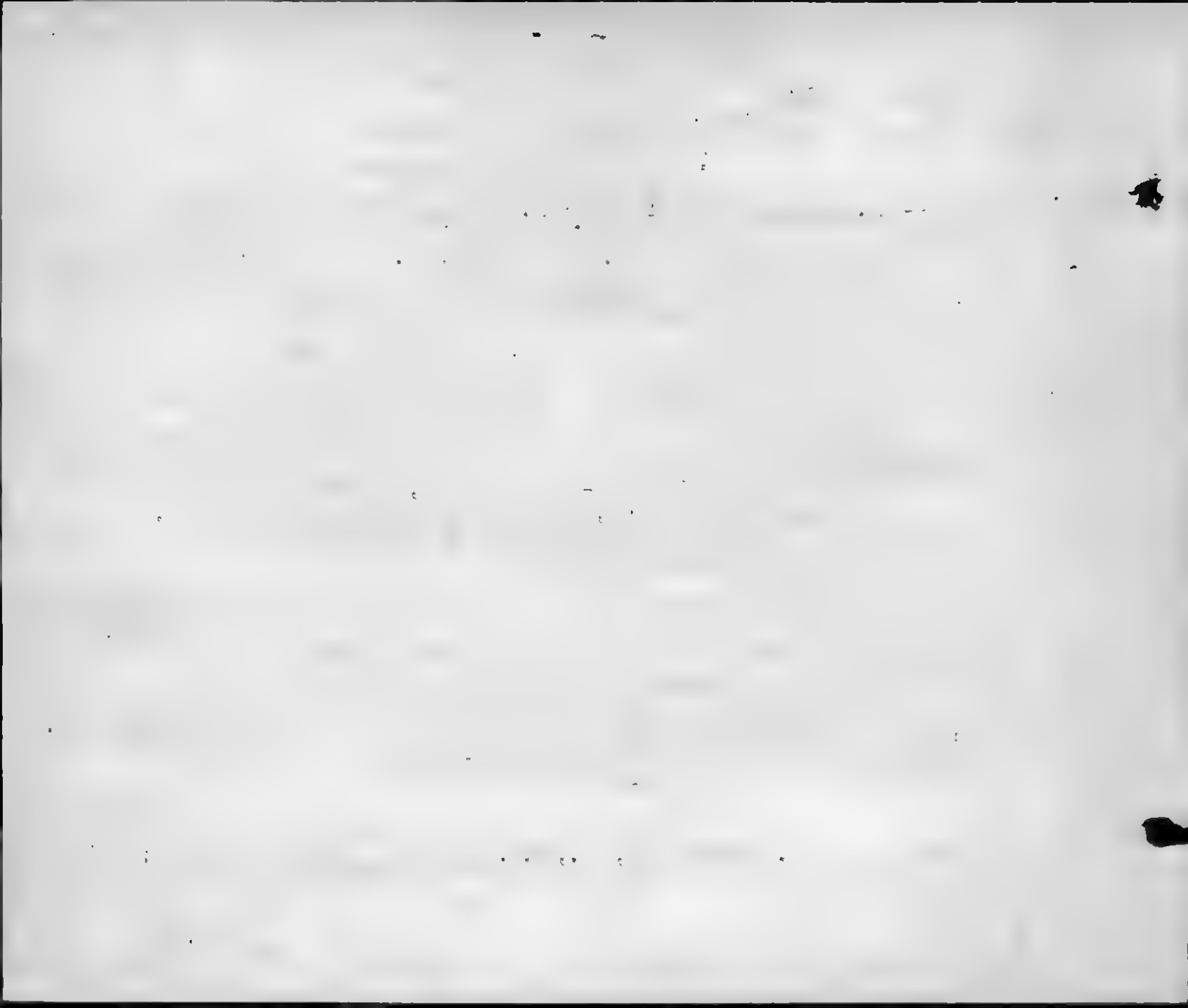
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

1759  
MAY 1960  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>1767 Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Scene -- Rt. 40, east of Middle River Rd. 804 LANNERTON RD. (50)</b>			
3. NAME OF DECEASED (Type or print) <b>CHARLES W. WHITE, SR.</b>		4. DATE OF DEATH Month Day Year <b>February 9 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-27-94</b>
9. AGE (In years last birthday) <b>65</b>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RAILROAD (RETIRED)</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>BLUEFIELD, W.VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL O WHITE</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA SIMPSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MR. C. W. WHITE JR. (SAME AS ABOVE)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple blunt-force injuries, as follows: multiple rib fractures, fractured spine, laceration of aorta, nearly complete transection of both lower legs, plus multiple head injuries</b> Conditions, if any, which gave rise to immediate cause (b) <b>DUE TO</b> (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pedestrian struck by auto</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>7:15</b> p.m. <b>2/9 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road</b>		20f. (City or town) (County) (State) <b>Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W. Bradley King, Jr., M.D.</b>		DATE SIGNED <b>2/10/60</b>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-12-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BALTO. NATIONAL</b>		22d. LOCATION (City, town, or country) (State) <b>BALTO. MD.</b>	
23. FUNERAL DIRECTOR <b>John S. Connelly 418 Eastern Blvd. (31)</b>		24a. REC'D BY REGISTRAR <b>FEB 17 '60</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	





1768  
CERTIFICATE OF DEATH

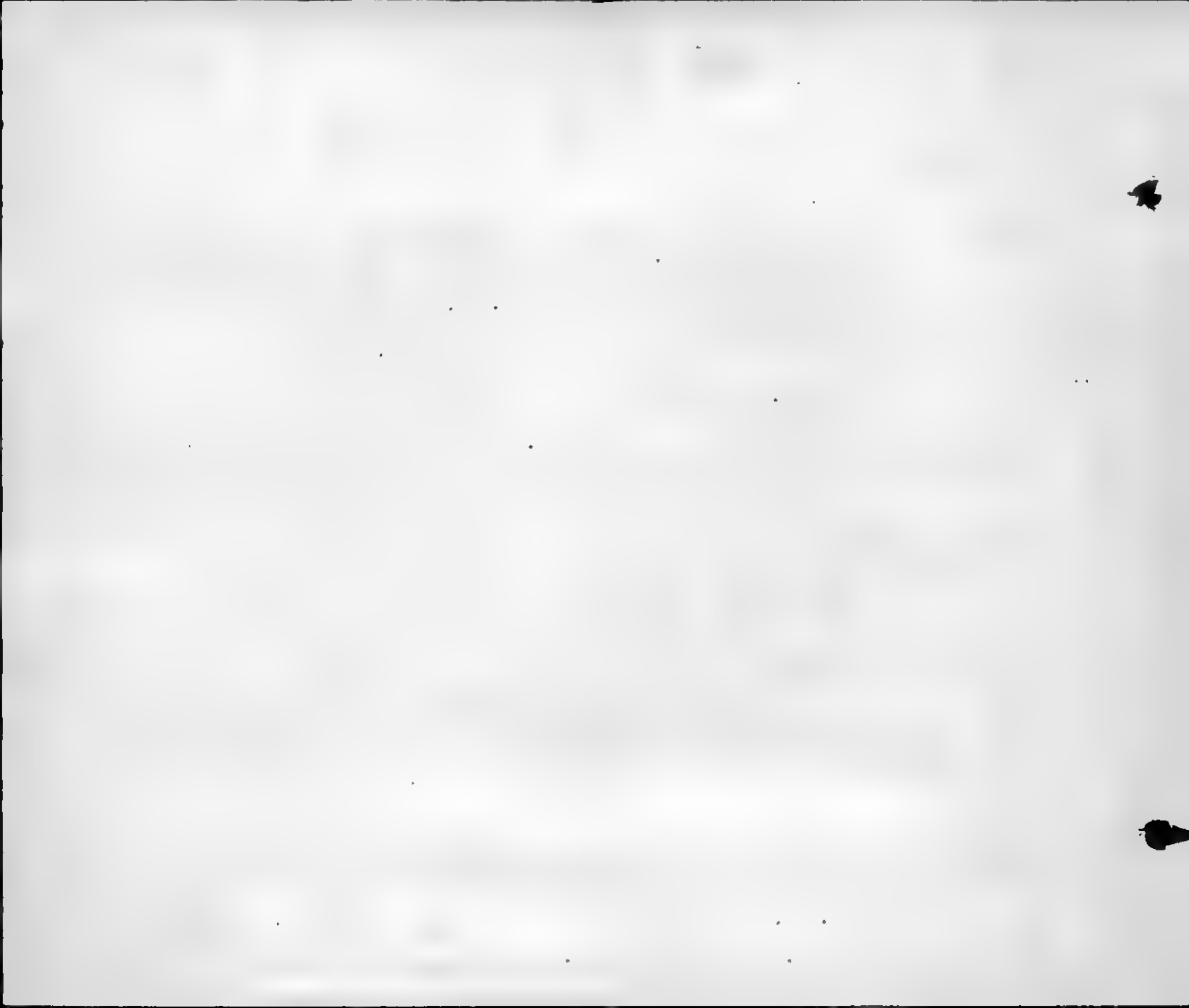
01760

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>1</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>				c. LENGTH OF STAY IN 1b <b>54</b> <b>Middle River</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>446 Whitethorn Way</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>C.</b> Last <b>WILLIAMS (KRATZ)</b>				4. DATE OF DEATH Month <b>February</b> Day <b>16</b> Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 30, 1880</b>	9. AGE (In years last birthday) <b>79</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George L. Schreiner</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Weber</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Mrs. Lillian Jenkins 446 Whitethorn Way</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>154X</b> DUE TO <b>Broncho pneumonia, Terminal</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the rectum with</b> (c) <b>Metastases</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>February 9, 1960</b> to <b>Feb. 16, 1960</b> , that I last saw the deceased alive on <b>February 16, 1960</b> , and that death occurred at <b>1:20 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Miguel A. Castro Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>805 FUSELAGE AVE</b>		DATE SIGNED <b>2/17/60</b>	
PHYSICIAN'S NAME (Type) <b>Miguel A. Castro Jr.</b>				<b>BALTIMORE 20, MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 20, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lilly &amp; Zeiler Inc. 1901 Eastern Ave.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 19 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kneen</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1560 CERTIFICATE OF DEATH

Reg. Dist. No.

01767

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Dundalk</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>75 Kershaw</u>	
3. NAME OF DECEASED (Type or print) First <u>Albert W</u> Middle <u>Wilson</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15 1899</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>10</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus. Mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steamship Svc.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Julia Jayce</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO <u>5-2-1</u>	
17. INFORMANT <u>Mr. Bertha Wilson</u>		Address <u>75 Kershaw</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer, left upper lobe lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Accident - August - 1956 =</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u>Aug</u> Day <u>1</u> Year <u>1956</u> Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office Bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Dundalk</u> <u>Baltimore</u> <u>Md</u>	
21. I certify that I attended the deceased from <u>August 1, 1956</u> to <u>Feb. 28, 1960</u> , that I last saw the deceased alive on <u>Feb. 22, 1960</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. B. Davis</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>6800 Mornington Rd</u> <u>2/28/60</u>	
PHYSICIAN'S NAME (Type) <u>M. B. Davis M.D.</u>		<u>Dundalk - 22</u> <u>2/28/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/2/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home</u>		ADDRESS <u>2112 Dundalk Ave</u>	
24a. REC'D BY REGISTRAR <u>MARK 2</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



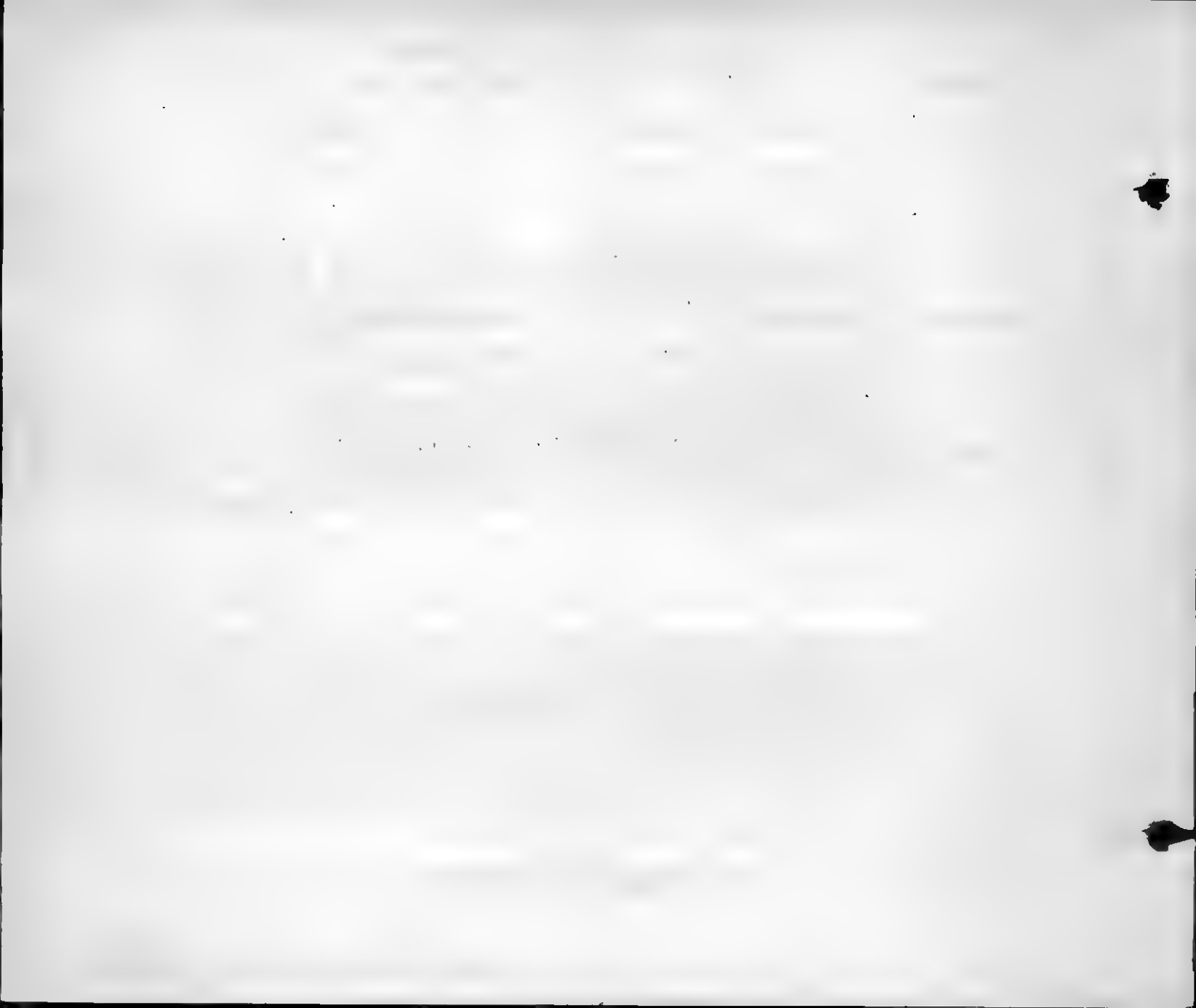
## 1762 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS POINT</u>		c. LENGTH OF STAY IN 1b <u>424</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>721 I STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katie</u> Middle <u>Alston</u> Last <u>Wise</u>		4. DATE OF DEATH Month <u>February</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-31-1865</u>
9. AGE (In years last birthday) <u>94</u> yrs		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>20</u> Hours <u>-</u> Min <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE Children Private Families</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WILKESBORO, S.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Nathan Martin</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Barclay</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>	
17. INFORMANT <u>Hattie Ringer</u>		Address <u>721 I Street</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac-Renal Disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis (General)</u> DUE TO <u>Senility</u> (c) <u>Senility</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>104 hrs</u> <u>204 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN. 4, 1958</u> , to <u>February 20, 1960</u> , that I last saw the deceased alive on <u>February 20, 1960</u> , and that death occurred at <u>3:50</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Wade</u>		ADDRESS (Street, city or town, state) <u>140 Oak Avenue</u> DATE SIGNED <u>2-20-60</u>	
PHYSICIAN'S NAME (Type) <u>William C. Wade, M.D.</u>		<u>Dundalk 22 Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>2-23-60</u>	<u>MT. C. ALVARY</u>	<u>A. A. COUNTY, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph B. Rock</u>		ADDRESS <u>1304 N. Central Ave.</u>	
24a. REC'D BY REGISTRAR <u>FEB 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. Kline</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Filed 2-8-60 at

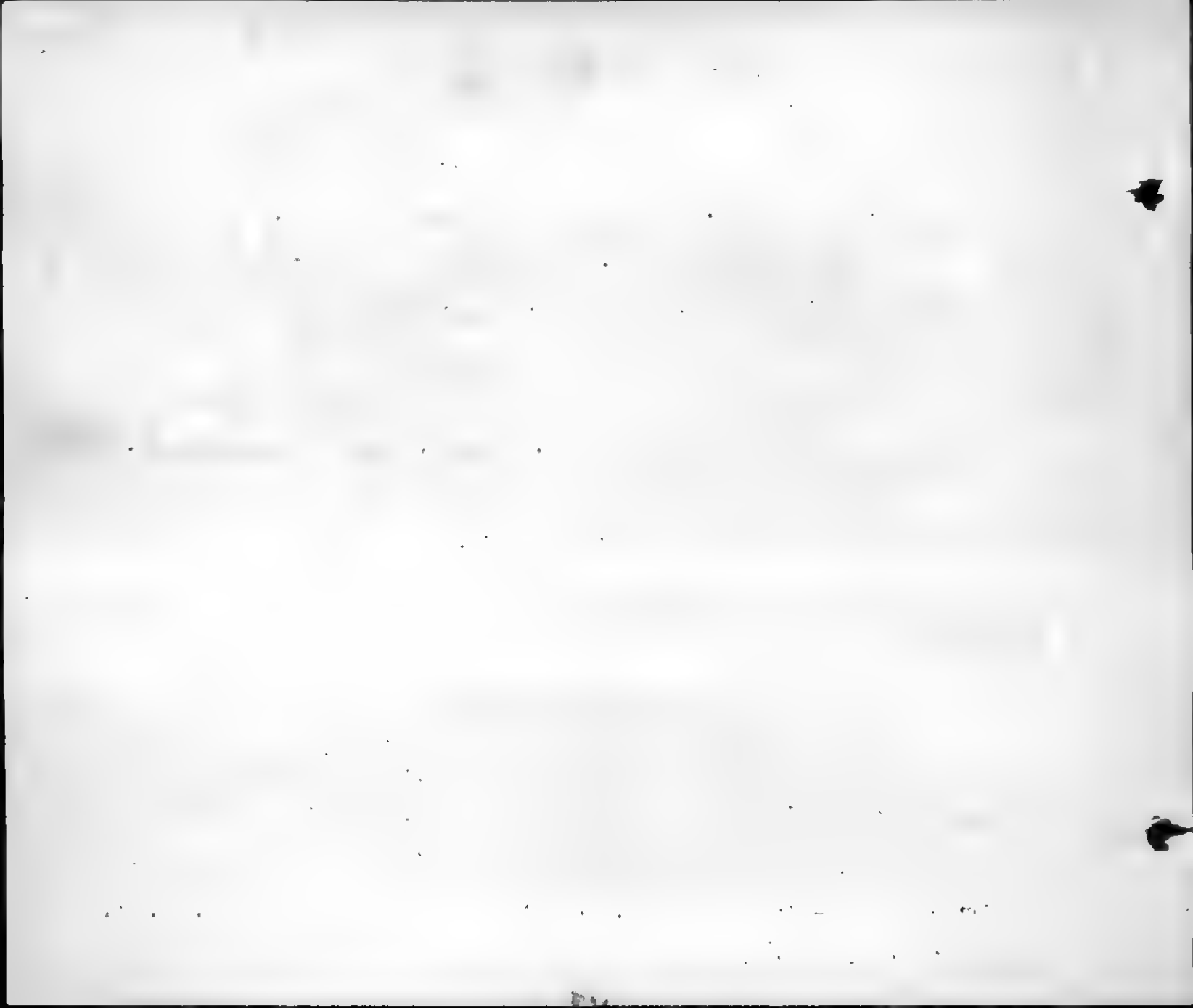
## CERTIFICATE OF DEATH

Reg. Dist. No.

01763

1779

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fullerton</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 298 Ridge Rd.</b>				d. STREET ADDRESS <b>Box 298 Ridge Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>M.</b> Last <b>Zengel</b>				4. DATE OF DEATH <b>Feb 2, 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 28, 1868</b>	
9. AGE (In years last birthday) <b>91</b> yrs.		10. UNDER 1 YEAR		11. UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Frank Leffek</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT Address <b>Mr. Joseph A. Zengel Box 298 Ridge Rd. 6</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Natural causes -</b>							
450.0 DUE TO <b>Generalized arteriosclerosis</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO							
(c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Nov</b> , 19 <b>59</b> , to <b>Feb 2</b> , 19 <b>60</b> that I last saw the deceased alive on <b>January</b> , 19 <b>60</b> , and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Leopoldo Gross</b> M.D.				ADDRESS (Street, city or town, state) <b>201 Ballard Ave Baltimore 20, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Leopoldo Gross M.D.</b>				DATE SIGNED <b>Feb 2, 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-5-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's</b>		22d. LOCATION (City, town, or county) (State) <b>Fullerton Balto. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lanahan Funeral Home</b>				ADDRESS <b>7401 Belair Rd.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 3 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			





# 1 1565 CERTIFICATE OF DEATH Reg. Dist. No. 01765

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garnes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
c. LENGTH OF STAY IN <u>6 weeks</u>		d. STREET ADDRESS <u>3413 Claremont Ave</u>	
d. NAME OF HOSPITAL (If dead in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Laura E. Ziegenfelder</u>		4. DATE OF DEATH <u>Feb. 15</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16 - 1874</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Andrew Kane</u>		14. MOTHER'S MAIDEN NAME <u>Annie Klineyoung</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. Andrew Ziegenfelder</u>		Address <u>3413 Ave Claremont</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension Cardio-vascular disease</u> 443X DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 2/14</u> , 19 <u>56</u> , to <u>2/15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/14</u> , 19 <u>60</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph R. Liberto</u>		ADDRESS (Street, city or town, state) <u>3508 Birch St - Baltimore 24, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH R. LIBERTO</u>		DATE SIGNED <u>2/16/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 18/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip Herwig Sons Orleans St</u>		ADDRESS <u>2024</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kline</u>	
DATE <u>FEB 19 1960</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1771  
CERTIFICATE OF DEATH

Reg. Dist. No.

01764

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>3yr10mth12dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>319 Lynhurst Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Selma</b> Middle <b>Zigmont</b> Last				4. DATE OF DEATH Month <b>February</b> Day <b>29</b> Year <b>19 60</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 5, 1898</b>	
9. AGE (In years last birthday) yrs. <b>61</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Tomoshocokas</b>				14. MOTHER'S MAIDEN NAME <b>Salome Oshenskis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>				16. SOCIAL SECURITY NO. <b>218-07-6477</b>			
INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Art. blood Cardio Vasc. Disease</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 30, 1956</b> , to <b>Feb. 29, 1960</b> , that I last saw the deceased alive on <b>Feb. 29, 1960</b> , and that death occurred at <b>8:20 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 2-29-60</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-MAR-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>DUNDALK MD MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles W. Ischaewski</b>				24. REC'D BY REGISTRAR <b>MAR 4 '60</b>			
ADDRESS <b>637 W. 1st Bldg.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

